Forensic Psychological Advice Report

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Addressed to: The Nottingham Inquiry

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(BPS Chartered, HCPC Registered)
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Specialist field: Forensic Psychology

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WITN0358001_0001

Executive summary

1. This independent expert witness report has been commissioned by The Nottingham Inquiry into the offences committed by VC in June 2023. VC had been known to mental health services.

2. The instructions focus on risk assessment, and specifically the **HCR-20v3** structured professional judgment (SPJ) violence risk assessment tool [**WITN0358002**] and which I respond as a Forensic Psychologist experienced in its use who is also familiar with the related research literature, and as a professional who trains others in this tool. All references to **HCR-20v3** in this report refer to **WITN0358002.**

3. Risk assessment approaches and the tool are described, and specific questions related to the tool's design, the training of professionals, and use of the tool are responded to in section 2 of this report.

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1. Introduction

1.1 Report writer

1.1.1 I am Dr Ruth Tully, a Health & Care Professions Council (HCPC) Registered, and British Psychological Society (BPS) Chartered Forensic Psychologist. I work in private practice and relevant to the current instruction is that a large portion of my work involves completing violence risk assessments, supervising the work of others who complete such assessments, and I also provide formal training to professionals in the use of various forensic risk assessment tools that professionals can then use to aid their assessment of violence risk.

1.1.2 My CV is detailed in Appendix I; a summary of my relevant qualifications and career is provided in section 2 of this report in response to the instructions.

1.2 Basis of report

1.2.1 I have been asked to complete an independent psychological advice report as an expert witness to aid The Nottingham Inquiry, instructed by Farhana Rahman-Cook, Solicitor to the Nottingham Inquiry. To indicate the basis of this report and to contextualise my instructions, I include below the facts provided to me by the Inquiry (letter of instruction, 23.09.2025):

On 13 June 2023, VC brutally killed Barnaby Webber, Grace O'Malley-Kumar and Ian Coates in Nottingham city centre, before driving into and seriously injuring three pedestrians, Wayne Birkett, Sharon Miller and Marcin Gawronski.

Prior to the attacks in June 2023 VC interacted with health services for management of mental health conditions, and with the police.

In November 2023, VC pleaded guilty to manslaughter by reason of diminished responsibility in relation to each of the three killings. He also pleaded guilty to attempted murder for the three further attacks. On 25 January 2024, VC was sentenced to a hospital order and restriction under s37 and s.41 of the Mental Health Act 1983.

The Inquiry will take account and build upon the reviews that have already been undertaken that have considered agency involvement with VC and the attacks on 13

June 2023, in particular those by the Care Quality Commission and Theemis Consulting Ltd, instructed by National Health Service England.

1.2.2 In taking on this instruction I have not had access to any documents, other case material, or contact with involved professionals in relation to this case; the documentation provided is limited to the letter of instruction. I liaised with members of the Inquiry by video call on 27.08.2025 prior to instruction to discuss whether or how I may assist the Inquiry. To try to contextualise my responses I looked at the chronology provided in the publicly available NHS England commissioned independent report (page vi)[1]. I have also liaised with the instructing solicitor by email.

1.2.3 My instructions and responses to each are detailed in section 2 of this report. An index is provided in Appendix II and a glossary of terms is provided in Appendix III.

1.3 Conflict of interest

1.3.1 I am independent and my duty is to public protection regardless of who has instructed me, regardless of how the report has been commissioned, and regardless of how the report is being funded. My independence and duties are in line with the Standards of Practice of the HCPC, which I am bound to follow as a Registered Psychologist. I have outlined all potential conflicts of interest of which I am aware in Appendix III of this report, and I did not consider that these compromised my ability to provide an independent response to the instructions provided but have provided details of these for transparency for the reader.

1.3.2 This case was widely reported in the media at the time of the offences and at various stages afterwards. I am certain that I have seen this case reported in the press, and I am aware that any press reporting will not have or report the full facts of the case. I do not believe that the media reporting affects my independence or ability to respond to these instructions.

1.3.3 I am writing this report as an independent psychologist in private practice. Although I

[1] https://www.england.nhs.uk/midlands/wp-content/uploads/sites/46/2025/02/independent-investigation-into-the-care-and-treatment-provided-to-vc.pdf

was previously employed by various organisations, it is important to note that I have not had access to any information regarding this case via any past or current credentials. As mentioned, the only information provided to me has been the letter of instruction, which outlines context.

1.3.4 As is recommended for practitioner psychologists as best practice (BPS, 2024), I engage in peer supervision. I can however confirm that all opinions as expressed within this report are entirely my own. Appendix V details the statement of truth.

2 Instructions and responses

2.1 Introduction to opinion

1-4: Provide a short summary of your qualifications and career summary, relevant appointments and memberships, training and expertise in HCR-20v3 and role in providing training in it. Please explain the difference between a forensic psychologist and (i) a clinical (or other types) of psychologist; (ii) a general psychiatrist; and (iii) a forensic psychiatrist as regards the work they do in the management and risk assessment of patients.

2.1.1 **Career and qualifications summary:** I am a Health & Care Professions Council (HCPC) Registered, and British Psychological Society (BPS) Chartered Forensic Psychologist. I hold a BSc. (Hons.) degree in Psychology and Counselling Studies, MSc. Forensic Psychology and Crime, and I have also been awarded the Professional Doctorate in Forensic Psychology (DForenPsy). The DForenPsy is modelled on the clinical psychology training process and like that process involves academic/research study as well as clinical placements spanning different client groups and settings. The main difference is that, unlike clinical psychology training, the forensic psychology doctorate clinical placements are *all* required to be specialist forensic placements. Alongside clinical placements, my Doctoral level study involved extensive research into sex offender risk assessment, complementing a total of over eight years of working for what is now known as HM Prison and Probation Service (HMPPS) specialising in the assessment and treatment of men who have committed sexual and/or violent offences. I have worked in inpatient and community forensic

psychiatric NHS services. I have completed many other professional training programmes and events during my career including 'in house' training within services that I have worked in, and those external to the service that I was working in.

2.1.2 My wider experience includes working with adult and young offenders and patients in secure healthcare, prison, and community settings. I am experienced in various areas of assessment and intervention including substance misuse, general offending behaviour, violent offending (including general, partner, and extremism/ideology-based violence), sexual offending, learning disability, mental health, trauma, and personality disorder. Relevant to the current instructions I have worked with people who have been at risk of or committed violence who have a primary diagnosis of schizophrenia and who are detained under section, or who are in the community.

2.1.3 I have worked with a variety of universities, and I deliver teaching and training on topics including forensic risk assessment and treatment, with students ranging from undergraduate to doctoral level. I train other professionals to use risk assessment and personality assessment tools competently and ethically. I am an invited speaker at various conferences on the topic of risk in the context of both research and practice, and I was awarded the BPS Junior award in Forensic Psychology 2013 for *notable contribution to the field*. I am also a Fellow of the BPS, which is the highest level of membership, and which was awarded to recognise my experience and contributions to the field of Forensic Psychology. I hold European Psychologist status. I am a 'partner' of the HCPC which is the statutory regulatory body for practitioner psychologists (and some other health professions in the UK), and within this role I sit on fitness to practice panels relating to HCPC Registered Practitioner Psychologists across domains (i.e. not limited to those registered in the domain of 'Forensic'). I am currently undertaking post-graduate study in clinical neuropsychology. I work for my own company where I complete clinical and expert witness assessments, including risk assessments, in parole, crime, and family cases. In criminal cases I regularly complete expert risk assessment instructed by the prosecution/police, or by the defence. I have received a Judicial commendation for my expert risk assessment and report in a complex criminal case.

2.1.4 **Expertise in use of and training in the HCR-20v3**: I have extensive experience of assessing people with violence risks, having conducted and/or clinically supervised in excess of 2000 sexual / violence risk assessments. This includes use of the HCR-20v3. I am unable to say exactly how many HCR-20v3 assessments I have completed, but this will be likely over 1000 in my career. This includes completion of these in forensic psychiatric inpatient, community, and prison settings. I have completed these as a sole practitioner, and also as part of a multi-disciplinary team (the latter being how these assessments are in my experience often undertaken in NHS forensic psychiatric services). My day-to-day work for the last few years has typically involved violence risk assessment in some way (forensic practice, research, training professionals, and supervision). I provide case and peer consultation and supervision to psychologists who work with me as employees or sub-contractors and some who are external to my own company. Additionally, I have published in peer reviewed journals and books in the area of forensic risk assessment including specifically in relation the HCR-20v3. I complete expert witness reports in various case types including criminal, family and parole/prison cases, and have been (and continue to be) instructed by the prosecution/police (or prison law equivalent) and defence solicitors in such cases. I have given professional (when working for a service) and expert (independent expert witness) oral evidence in relation in relation to my use of HCR-20v3 in many cases. I do not know the exact number, but this is well over 100 cases.

2.1.5 **Training others in HCR-20v3:** In this section I will avoid overlap between general information about my training of others, and the specific questions posed about training detailed below. I am an 'author approved' or 'licensed' trainer of the HCR-20v3 violence risk tool; the tool is described later in this report. I have trained hundreds of professionals in the ethical and competent use of this and other similar risk tools nationally and internationally. I trained professionals in the use of the HCR-20v3 before the authors launched their approved 'train the trainer' programme and me becoming 'licensed'. I do not have a record of exactly how many people I have trained in the use of HCR-20v3 in my career, but a reasonable estimate is at least over 1000 professionals.

2.1.6 <u>'Author approved' or 'licensed' trainer:</u> Being an 'author approved' or accredited trainer in HCR-20v3 means that I train people to use the tool using training materials provided by the tool's authors, which I have adapted for a UK psycho-legal context (the authors are based in Canada and I include reference to UK based studies and discussion of the UK legal context in the content). The training materials remain the property of the authors. To 'train to train' and be 'approved' and licensed by the tool's authors' company, 'Protect International', in 2016 I applied with my CV to demonstrate my competence and expertise in the clinical use of HCR-20v3, completed some written assessed work showing understanding of the tool, submitted an example HCR-20v3 assessment report, undertook a training programme to train others delivered by the tool's authors (Kevin Douglas and Stephen Hart), completed training case studies using the tool, with follow up including delivering part of the training to the authors' team for them to assess whether they 'approve' me as a licensed trainer. The author's train-the-trainer programme is described by the authors as a programme allowing them to endorse other trainers by directly evaluating their knowledge of general principles of violence risk assessment, their familiarity with the professional and scientific literature concerning HCR-20, skills in the use of HCR-20v3, skills in respect of training professionals, and the accuracy of training materials. The main way in which I have implemented this training and knowledge in respect of training others is via offering training to professionals via 'open' training events. Open events are those which individual professionals can book on to (some services book several of their employees onto this training) which results in professionals from many different backgrounds, regions, and services attending the same training. Upon request I also offer / deliver 'closed' training whereby I have provided training to a specific team or service where the event is delivered just for them. All of the HCR-20v3 training I delivered was previously delivered in person, but following the COVID pandemic this was adapted to be online (live) training with the same content and duration. I do not deliver/offer pre-recorded HCR-20v3 training. I am not authorised by the authors to train others to train people in the use of the tool. I offer the training only to UK and Ireland based participants which is part of my agreement with the authors. I pay a license fee to Protect International 'per head' trained. Protect

International do not assume liability for my work as a trainer. I do not assume liability for the work of any person or organisation I train. I do not assess the competency of individuals who attend the training. The responsibility for use of the tool lies with the user. Other people (including those not licensed by Protect International) can and do train professionals in HCR-20v3 as will be discussed later.

2.1.7 **Difference between registered Forensic Psychologists and clinical (or other) type of psychologist as regards the work they do in the management and risk assessment of patients:** Note that in my response I have taken 'risk' to mean violence risk rather than risk to self or risk of relapse. To add context to my response to this question, all of a forensic psychologist's training while on an HCPC approved doctorate level or similar programme is forensic. Forensic in this context could generally be taken to mean working with perpetrators and/or victims of crime and/or working occupationally with professionals working with these groups Some of a clinical psychologist's route to HCPC registration *may* be forensic but it is possible that none of it may be forensic. Typically, but not necessarily always, a forensic psychologist's pre-qualification training would (amongst many other competencies) involve developing and evidencing competency and experience in violence risk assessment. This may not be the case for a clinical psychologist's training route, although certainly *can* be the case in my experience depending on a clinical psychology trainee's placements, supervisor, and placement-specific training. When an NHS mental health service is not a forensic service, psychologists working there are more likely to be clinical than forensic due to the training and experience of those registered in the 'clinical' or 'forensic' domain. Counselling psychologists may also be more likely to work in non-forensic settings than forensic settings (although some counselling psychologists can and do work in forensic settings). Note that it is possible for a psychologist to be HCPC registered in more than one domain (e.g. forensic and clinical, clinical and counselling). There are other types of HCPC registered psychologist although it does not seem relevant to detail these here.

2.1.8 The answer to this question about the role of forensic / clinical psychologists with violence risk assessment / management may depend on the type of service that the

psychologist is working in (forensic mental health, or non-forensic mental health). It is my experience that where psychologists of different domains (mainly clinical or forensic) work in forensic healthcare services (e.g. forensic psychiatric inpatient, forensic community team), then their work is largely the same (e.g. psychologists of both modalities are likely to be involved in psychological assessment, risk assessment, and psychological treatment related to violence risk). However, the *exact* role of each psychologist in a team (whether there is one, or more than one psychologist) may vary locally and it is entirely reasonable that one psychologist may have certain roles that another psychologist may not have, dependent on interests and clinical experience or expertise.

2.1.9 I am less able to comment on the role of a psychologist in non-forensic mental health services in the violence risk assessment of patients, as my experience mainly lies in forensic services; it seems reasonable to assume that demand / need for violence risk assessment would be much less likely to be routine outside of a forensic service. Being known to mental health services does not mean that all patients require violence risk assessment. However, *if* violence risk assessment is conducted in that setting (as opposed to, for example, the non-forensic service linking in with a forensic team for consultancy / to conduct such assessment where it is required), I would typically expect that a psychologist or psychiatrist (i.e. someone of suitable seniority in the team who has a good understanding of psychological functioning, mental health, and violence risk) may take the lead on violence risk assessment, or at least be involved or lead where such assessments are completed as a team rather than authored by one clinician.

2.1.10 If a forensic psychologist works in a non-forensic service, if violence risk assessment is needed, then given their forensic training one might expect it to be more likely that they, as opposed to a clinical psychologist when the clinical psychologist does not have forensic / violence risk experience, might undertake violence risk assessments in that service. It is important to note that if a psychologist is not trained in violence risk assessment, then unless they otherwise felt competent to complete these assessments (e.g. through work experience and self-directed upskilling,) it is possible

that they may not undertake these assessments. This is because, although for instance with the HCR-20v3 attendance at formal training programmes is not strictly required (as will be discussed below), psychologists are required to act within their competency at all times according to their HCPC registration. Registered psychologists are required to form their own judgment of what is or is not within their competency. It is in my view reasonable that a psychologist, regardless of whether forensic or clinical, without formal training in violence risk assessment may consider that to complete such assessments would not be appropriate on this basis. It is also reasonable that a clinical or forensic psychologist with suitable competence could conduct violence risk assessments in a non-forensic mental health setting.

2.1.11 **Difference between psychiatrist and forensic psychiatrist as regards the work they do in the management and risk assessment of patients:** Note that in my response I have taken 'risk' to mean violence risk rather than risk to self or risk of relapse. I am not a psychiatrist, and my work has mainly been in forensic services in which the psychiatrist has been a forensic psychiatrist, and so I cannot fully respond to this question. Reasonably as with the above response, the role of the psychiatrist within violence risk assessment may vary dependent on whether the service is forensic or non-forensic. Forensic psychiatrists would be more likely to work in forensic settings than general psychiatrists in my experience. Forensic psychiatrists would be less likely to work in non-forensic services in my experience. I can say through my experience in forensic services working with forensic psychiatrists (mainly with patients subject of an order), that forensic psychiatrists tend to be actively involved in violence risk assessment processes whether this is the psychiatrist completing a risk assessment of the patient as an individual clinician, completing this in collaboration with their team members, or in the case of niche or specialist types of risk assessment (e.g. sexual risk) in which all team members may not be trained, this may involve another team member such as the psychologist completing a risk assessment to help inform the psychiatrist's views about risk; as the responsible clinician[2] the psychiatrist can

[2] Not all Approved Clinicians are psychiatrists, and can be psychologists where the psychologist has undertaken specialist training, but the majority are psychiatrists.

interpret the risk assessment of other individuals to help them form their own views as needed.

2.2 Risk assessment tools

5. Please explain what risk assessment tools are and discuss their predictive value.

2.2.1 A risk can usefully be considered to be a hazard that is not completely understood, and therefore, its occurrence can only be forecast with uncertainty. The 'hazard' we are concerned with here is violence. Violence risk is complex (e.g. nature, severity, imminence, frequency) and is also contextual and dynamic (e.g. may be influenced by living situation, available services, motivation, stressors, and so on). For these reasons, risk is subjective and speculative in nature, is all about uncertainty, and risk assessment is not an attempt to predict the future; risk assessment is an attempt to identify a range of plausible futures, to consider uncertainties, and risk assessment should go hand-in-hand with risk management planning. The ultimate goal of violence risk assessment is to prevent violence and thus protect the public, by considering and combining risk factors, to guide the development of effective risk management plans. Risk assessment in the clinical context is therefore about risk reduction and management rather than prediction. Violence risk assessment tools have been developed to aid this process so that clinicians have a structured and systematic manner to aid them in assessing risk.

2.2.2 Violence risk assessment tools are formal, structured approaches to assessing violence risk. Developers of these tools tend to design them based on the research literature as to what 'risk factors' for violence are (i.e. they look at the evidence base), and they develop frameworks that encourage clinicians to pay attention to these risk factors in assessing risk at an individual level. A description of what a 'risk factor' for violence is may depend on someone's choice of psychological theory in which to frame this, but if it is accepted that violence involves a person making a decision (i.e. their actions are based on thought, a message going from the brain to the hand to punch someone for example, even if the thought is impaired by something like serious mental illness) then risk factors can usefully be described as being the things that influence decisions to

commit violence. Risk factors may influence violence by playing a causal or contributory role (e.g. motivator, disinhibitor, or destabiliser) or it may be that a risk factor is something that complicates or affects risk management in some way.

2.2.3 The 'predictive value' of risk assessment tools will be discussed below as my response varies between type of tool.

6. a) Please explain the different types of tools (i) structured professional judgment approach; (ii) unstructured clinical risk assessments; (iii) actuarial approaches to risk assessment; (iv) any other type you know about. b) Please explain the risks and benefits in these various approaches.

2.2.4 I will respond to this in a slightly different order than i, ii, then iii given the way in which risk assessment tools have developed over the years. Importantly, no risk assessment approach is without limitations, and no approach claims to be 'perfect'. Violence risk assessment can only claim to estimate risk. If tool outcomes are used to attempt to predict violence, all approaches can result in 'false positives' (where someone is assessed as high risk who may not in fact have been high risk and does not commit violence) and 'false negatives' (where someone is assessed as low risk who may have been higher risk and goes on to be violent). There is no certainty in risk assessment, as human behaviour is complex, as is the environment and context, and the decision to commit violence lies with the perpetrator whose motivations, thoughts, and inner experience are often invisible to those around them. No risk tool or approach claims to be perfect and there is no tool with perfect predictive value.

2.2.5 Unstructured clinical judgment (UCJ) violence risk assessments: Before risk assessment tools were developed, clinicians used to have to rely on unstructured clinical judgment (UCJ). This can be described as an informal, or impressionistic discretionary approach. One might hope that the clinician had some knowledge of factors that the literature suggests link to violence as well as the facts of the case when forming their judgment on risk, but this was not necessarily the case, and this approach does not involve structure or a tool for guidance. NICE guidelines (NG10) on 'violence and aggression: short term management in mental health, health and

community settings' are somewhat outdated and are under consultation for update[3], and the forthcoming update is due to consider structured risk assessment (towards which I provided stakeholder comment[4]), but it is relevant to highlight that even these 10+ year old guidelines advise against using UCJ alone (although specify 'in inpatient settings'). Predictive validity of using risk assessment tools has recently been found in a systematic review to be significantly higher than when using UCJ, with tools continuing to outperform UCJ even when accounting for risk of bias (Vilojen et al., 2025). UCJ performs little better than chance.

2.2.6 UCJ strengths: It could be argued by some that a strength of this approach may be that it results in a truly individualised violence risk assessment and can be done very quickly. The clinician can use their own expertise and experience with violence risk and patients to inform their work.

2.2.7 UCJ weaknesses: As mentioned above, UCJ is outperformed by risk assessment tool use. Therefore the 'predictive value' of this approach is limited. Drawbacks that may result in this method not being effective may include the potential consequences of increased risk of subjectivity (whether that results in over- or under-estimation of risk), or lack of attention to literature (through lack of structure increasing the risk of missing an important risk factor or assuming that some factor may be a risk factor when it is not). It is an approach that in some senses is 'fuzzy' and can lead to non-specific or broad descriptions about risk without discussion of scenarios of violence or things that might increase or decrease risk. It can be unstable; an evaluator's impressions of risk may vary rapidly from one day to the next without sound justification, and this method also lends to the risk that risk judgments may vary wildly from one assessor to the next, as they may not be basing their views on similar factors due to lack of systematic or consistent approach.

2.2.8 Actuarial violence risk assessment: This can be described as a non-discretionary approach to violence risk assessment, in which information is selected, weighted, and

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[3] https://www.nice.org.uk/guidance/gid-ng10432/documents/draft-scope-pdf-version

[4] https://www.nice.org.uk/guidance/gid-ng10432/documents/consultation-comments-and-responses (page 101-102)

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combined using fixed rules dictated by the tool (and which are not at the discretion of the assessor). Typically, items are scored according to the tool's algorithm, and the score places them in a risk banding such as low, moderate, or high. The person's result is then compared to a dataset of violent offenders, and a probabilistic estimate of violence in a given timeframe can be provided by comparing the individual's outcome to those in the research sample who scored similarly and outcome might be communicated by stating what percentage of those people in the research sample, who scored similarly to the person being assessed, violently reoffended. For example, the outcome might be reported as 'Mr X scored within the high-risk group. Research has shown that xx% of people in the high-risk group received a violent reconviction within 2 years, and xx% received a violent reconviction within 4 years'. In some tools the score is translated into a probability of violence e.g. 0 – 100%. As can be inferred from this, such tools most often rely on proven reconviction data (which does not represent actual recurrence of violence which will be at a higher rate than reconviction data suggests). The outcome of these tools of course does not tell us whether the individual will be like the percentage who reoffended, or the percentage who did not. This approach can also be referred to as algorithmic, mechanical, or statistical.

2.2.9 There are not many violence actuarial tools used or validated in the UK. There is more research evidence in actuarial tools for sexual risk in the UK which is not relevant to discuss further here. Outside of the OASys[5] Violence Predictor (OVP; see Howard & Dixon, 2012) which is built into probation's OASys tool and therefore is used with people under their supervision only. It was developed using OASys data and police national computer reconviction data. The OVP generates a risk summary score based on items within the OASys system. The only other actuarial tool I have seen used very occasionally in the UK is the VRAG (current version VRAG-R; see Rice et al., 2013) originally developed on a Canadian sample of released forensic psychiatric patients, designed for use in forensic psychiatric settings. There is some, but limited, validation research on this tool with UK samples. Validation research is important for actuarial

[5] OASys is a risk and needs 'offender assessment system' used by probation for those under their service, and it contains actuarial measures of risk calculated based on the information inputted by probation practitioners.

tools, because the premise is statistical comparison of the individual to the group in research and so how this translates between jurisdictions and sub-groups is relevant. The Parole Board of England and Wales (appropriately in my opinion) caution their panel members against relaying solely on the VRAG instrument[6] (with the implication that this is because it is a solely static tool). NICE guidelines (NG10) from 2010 recommend an actuarial tool called the BVC (Woods & Almvik, 2002) which is a 6-item checklist that was developed in Norway in a high secure mental health setting and has some support in inpatient settings but limited UK research (Hvidjelm et al., 2023) or the DASA-IV (Ogloff & Daffern, 2006) which is based on the BVC but again this is an inpatient-developed tool exploring short-term risk with some limited empirical support. The approach of actuarial tools is prediction rather than risk management. In general, actuarial risk tools have been found to be significantly more accurate than UCJ in predicting sexual, violent, and any reoffending (e.g. Hanson & Mourgon-Bourgon, 2009).

2.2.10 Actuarial strengths: The risk factors included in such tools are empirically based, that is, they have been found to correlate with or link to the recurrence of violence. These tools are transparent and clear; clinicians can explain to the person being assessed why they have scored as 'high' risk for instance, as the items are historical features of their case (e.g. number of violent convictions) and less open to subjectivity than psychological concepts included in other types of risk tools (e.g. problems with insight). These tools are quick and relatively easy to administer if the assessor has access to the case file information (most items can be scored from case files and don't require interview or clinical assessment) and can follow a manual; therefore, they can be helpful screening tools in services that have high volumes of service users, and few treatment spaces, to see who may need higher intensity treatment than others, perhaps prior to a more in depth assessment. If one had the relevant information available, then these tools can take only minutes to calculate. I can say that overall, there is some empirical basis in relation to prediction to support the use of actuarial

6 https://assets.publishing.service.gov.uk/media/66d1b5c08df4724cad1aead3/Risk_Assessment_Guidance_v2.0_-_External_version.pdf

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tools although based on the weaknesses described below, their wider 'value' will depend on what the task of the assessor actually is (i.e. reasons for completing a risk assessment).

2.2.11 Actuarial weaknesses: The actuarial violence risk assessment approach was developed linked to problems identified with UCJ (e.g. lack of structure and consistency), and it follows that its problems tend to be the opposite of the problems with UCJ. The actuarial approach can be simplistic and arbitrary, lacking the flexibility to deal with unique characteristics of the case and person; the assessor considers exactly the same risk factors in every case, and weights them all the same in every case. In some respects the approach assumes the 'problem' with violence risk assessment is the assessor / evaluator, and the 'solution' in the actuarial approach is to limit the assessor, defining risk as probability, using algorithms; but in doing so it is a rigid approach that is fixed and insensitive to change. For example, someone could score as 'low' risk on an actuarial tool, yet tell you that they plan to be violent, and mean it, and the tool would not have an 'item' to account for this and the risk level according to the tool would remain the same. The individual may have a very important risk factor active, but if the tool does not have this as a risk 'item' then their risk could be underestimated. These tools also cannot take into account risk reduction through the person addressing their violence risk factors successfully or through positive therapeutic change and they therefore neglect positive, mediating factors. Such approaches cannot consider 'grey' areas such as unproven allegations (for instance where one risk item might be 'number of violent convictions') or other behaviours that may indicate risk. The approach also does not lend well to risk management planning as it does not consider imminence (how soon) or severity (level of harm e.g. possible lethality versus common assault) of any future violent offending, nor does it lend well to identifying strategies that may decrease or manage risk as they rely on historical factors; it is a passive approach if used in isolation. Actuarial tools rely on samples of offenders to compare the individual to, within which the individual's wider characteristics may not actually be well represented (e.g. mental illness, history of sexual murder which is rarer than other types of violence, type of offence, or other relevant feature) and so the individual being assessed may be quite 'different' to those

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they are being compared to, which makes direct comparison less appropriate. The use of these tools on people not well represented in the validation samples is at the very least questionable (if not inappropriate entirely), and actuarial risk tools have been found to perform differently across sub-groups. Some have argued that while actuarial measures may predict at a group level, these tools result in "wildly" imprecise predictions for individuals (Starr, 2014), and others have concerns that these tools will over inflate and over predict risk in ethnic minority groups (e.g. Holder, 2014).

2.2.12 Structured professional judgment (SPJ) (sometimes referred to as structured clinical judgment or SCJ) violence risk assessment: The SPJ approach could be taken to be an approach which tries to deal with the problems of the UCJ (lack of structure and empirical basis) and actuarial (rigidity, focus only on prediction, lack of focus on risk management plans) approaches. SPJ tools rely on guidelines to structure the assessor's professional judgment, with the structure based on the inclusion of risk factors that have been found in the literature to link to violence risk. Typically, SPJs have a manual containing guidance about the steps and defining important concepts, which assessors are required to follow, but the items included are not all static / historical, and SPJs contain dynamic changeable factors that may affect violence risk for the individual. The steps of most SPJ tools are as follows:

1. Gather information (information reasonably necessary to form an opinion)
2. Assess the presence of risk factors
3. Assess relevance of risk factors
4. Formulation violence risk
5. Scenarios of violence
6. Risk management planning
7. Opinions (e.g. likelihood, imminence, level of harm, other considerations)

2.2.13 Most SPJ tools outline the steps above in a way which allows the user to follow a system or process, to ensure they don't miss any steps, and this is most often done in writing whereby the evidence for each risk factor is summarised and each item is rated (qualitatively, not in number form; often items are rated as either 'not present', 'partially/possibly present', or 'present'). In rare circumstances items can be omitted (e.g. where there is no reliable information on which to base an opinion). The approach of most SPJ tools allows assessors to consider the standard list of risk factors

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that the authors have included in the tool, and to add any 'other' risk factors as needed based on the case at hand. The 'formulation' step is where risk factors are considered together, looking at aetiology, links, and causation, but formulation is in essence a hypothesis, as it is an attempt to understand a person's violent behaviour, about which assessors will never be 'certain'. Plausible scenario plans of future violence are generated by the assessor, and assessors are typically encouraged to consider these along the lines of possible 'repeats' (of previous forms of violence), 'twists' (which is where something about the violence has changed, whether motivation or commission), and 'escalation' (such as a worst case or lethal scenario). This scenario planning step is important because it is a challenge to consider how to reduce risk if we cannot think about how it might manifest; it is not about 'predicting' what 'will' happen, rather it is about considering what may possibly happen. This assists the next step therefore, which is risk management planning; in this step, users are guided in most SPJ tools to consider at least monitoring, treatment, supervision, and victim safety planning (the latter being only reasonably possible in some limited cases e.g. identifiable victim or victim group). Finally, the assessor is guided to form opinions not just about likelihood of violence but also about imminence and severity, and whether immediate action is required, based on their overall assessment and scenario plans. These final opinions on risk level (level of imminence and likelihood for example) are not dictated by the tool or an algorithm within it (e.g. if x number of risk factors are present then risk is high), rather, the assessor can instead use their discretion, informed by the whole process of the risk assessment, to synthesize data and decide how much weight to place on factors. Rather than a score or numerical rating, generally the likelihood of violence and case prioritisation is described as low, moderate, or high (or somewhere in between e.g. moderate to high). SPJ guidelines are not intended to be prescriptive but build on the assessor's training and experience. By structuring the data collection while allowing for a more intuitive data commination process, the SPJ approach has been described as balancing both the discretionary features of the UCJ and the non-discretionary features of the actuarial approach (Hart et al., 2016)

2.2.14 In terms of 'predictive value' this is a complex area for SPJ tools, in that within research

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on a group level we look to whether the tool can discriminate effectively between those labelled as different risk levels (e.g. do high risk people commit violence more often / sooner / more seriously than low risk people?), yet on an individual level the assessment is about *risk management* and not *risk prediction* (which is a key point made by the authors of the most commonly used SPJ tools). This is because if the SPJ tool is applied in an individual case, it is not simply a risk assessment tool it is also a risk management tool within which management and reduction strategies are generated; if the strategies are implemented, then the ideal is that a person assessed as posing 'high risk' of violence may be supported and managed in such a way that they then do not go on to commit further violence. The same aim (to manage and support higher risk people more intensively) can be said to be the purpose for which most people would also use actuarial tools, but actuarial tools do not guide the focus and strategies of risk management; the focus of actuarial tools therefore is on prediction in respect of the tool itself whereas with SPJs the focus is on management. Thus, predictive value is somewhat complicated.

2.2.15 Added to this complexity is that even though SPJ tools are not intended to be used to derive total 'scores' (numbers), researchers (rather than clinicians) often do add up total scores on SPJ tools (i.e. converting qualitative ratings of items from not present, partial, and present to 0, 1, and 2), thereby using them in an actuarial fashion in assessing predictive value in a given sample. As a result, when interpreting research on predictive validity for SPJ tools, the reader should consider whether the risk rating being analysed was an SPJ risk estimate (e.g. low, moderate, high; which is more discretionary) or a total score (number; which is non-discretionary; see Challinor et al., 2021).

2.2.16 With that said, while SPJs have been found to be predictive in some of the literature, like actuarial tools they will have mixed results in different subgroups; there is research supporting their use and also some samples where the tool has not been predictive. However, overall, these tools can be said to have an empirical basis including in relation to prediction even though this is not their primary aim. They are commonly used throughout the justice system and in forensic mental health settings

and their use can be considered as current good practice (e.g. McMurran et al., 2025).

2.2.17 SPJ advantages: SPJ a more comprehensive approach than actuarial risk assessment and it allows for the complexity of risk (context, imminence, level of harm) to be considered. It is individual to the case at hand as it considers how the risk factors came about and resulted in violence (case formulation, which is the assessor making links between risk factors and considering how they influenced violent decision making and/or risk management) yet it attempts to balance being empirically based. The tool does not require attempts at prediction; it considers what *might* happen to allow for planning, not what 'will' happen. It does not require certainty, and assessors can evaluate a case and the required action in light of current knowledge. For example, non-convicted incidents of violence and allegations can be considered, as can the individual's general behaviour that might relate to an important risk factor that indicates increased risk (e.g. recent cognitive, affective, or behavioural 'instability' or increase in symptoms of 'major mental disorder'). SPJ tools encourage causal, systemic thinking in order to identify controlling factors, so that plans can be made to mitigate risk, using formulation that is individual to that case, rather than formulas. Research has, for example, indicated that members of the Parole Board for England and Wales find risk formulations valuable in identifying idiosyncratic risk factors and linking these to risk management strategies (McMurran et al., 2025). SPJ is a prevention-based approach, which assumes the problem is the task (that violence risk assessment is difficult) and provides structure and systematisation by supporting the assessor with guidance and procedures to help plan risk reduction / management actions. The approach is amenable to change and although the tool can be used to aid one-off decision making (e.g. in a court case to assist the judge in considering a person's risk pre-sentence), in health services where patients are under a service on an ongoing basis, if an SPJ is used, typically this *should* be reviewed, to account for risk-increasing factors and risk-decreasing factors. The approach allows context to be considered, both in terms of future risk, and also in light of the person's status e.g. inpatient versus outpatient, no restrictions versus being under a community treatment order (CTO). An SPJ tool can assist a clinician in answering questions about whether immediate action is required, whether detention is required (i.e. level of

supervision needed), and so on, but the outcome does not dictate decisions.

2.2.18 SPJ limitations: The application of the tool requires expertise (specialised knowledge, skills and experience) which for most professionals involves further formal training on top of a core professional qualification. The SPJ approach is a comprehensive assessment and not screening, which is a process that takes time (and therefore costs a service money in 'time costs') and is therefore not immediate. Unlike actuarial tools, the application of SPJ takes days rather than minutes / a couple of hours. An SPJ assessment should be reviewed with sufficient regularity in a given case to be considered 'current' and 'up to date', which again costs services time and therefore money, as well as diversion of professionals' resources from other tasks. Application of the tool can have limitations if completed from file review alone and should, where possible, be completed by including interview / direct assessment of the patient, and other collateral sources which can include file information, liaison with other professionals involved in the case, and any carer / observer information as relevant. Some of the items in SPJ tools, especially the dynamic items, are much more subjective than they are in actuarial tools (e.g. the item of 'recent problems with insight' in the HCR-20v3 is more subjective than adding up the number of prior convictions as might be included in an actuarial tool); although such dynamic items have a definition in the manual, there is more room for inter-rater disagreement on the rating of these more subjective items as compared to actuarial items. If used by an untrained / inexperienced person there is some reasonably significant risk of them not completing the assessment or rating items in line with the authors' intent for the tool's use. The use of the tool to formulate risk and generate scenarios and risk management plans involves some reliance on the clinician's experience and skills, which will vary from person to person (subjectivity); subjectivity may affect overall risk ratings. For example, risk formulations could, being more subjective, neglect relevant factors such as, potentially, cultural factors (e.g. McMurran et al., 2025) even though the formulation has the flexibility for these to be considered, as this relies on the assessor.

2.2.19 Summary: UCJ is not generally advisable and has severe limitations, although it should be noted that there may however be circumstances in which an UCJ is justified; for

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example, a patient may pose obvious high and imminent violence risks and immediate action is needed (such as an urgent detention for assessment under the Mental Health Act [MHA]) with no time to complete a more comprehensive risk assessment prior to that decision needing to be made. In such a case a clinician would have to use judgment in the available time. I would typically expect that a more comprehensive risk assessment is then completed when time is available. Given the limitations of actuarial non-sexual violence risk tools in general, and absence of tools designed for UK mental health and non-mental health populations, in my clinical work I do not use actuarial violence risk tools, but I do in some sexual risk cases as there are a couple of appropriate tools depending on the features of the case. However in my practice this is always supplemented by an SPJ tool, the format of which is described below. I would, in a violence risk case, pay attention to the actuarial OVP (probation assessment) if one exists in the case, and in doing so would consider if the OVP has any limitations when applied to the individual that I am assessing. However, my clinical choice is typically to use an SPJ where time allows. I consider that the use of such tools is generally empirically supported but not without limitation. The literature on all risk tools (actuarial and SPJ approaches) varies in terms of how effective individual tools and the approaches are, and it appears in the literature that some researchers / practitioners favour one approach over the other. However, both actuarial and SPJ approaches have empirical support that allows for clinicians to use their judgment as to what type of tool(s) to apply in given case. For instance, one systematic review found actuarial measures to perform better than SPJ measures in predicting violence (Hanson & Morton-Bourgon, 2009, albeit this was in sex offenders) but another systematic review found SPJ measures to perform better than actuarial (Fazel et al., 2012, violence in psychiatric patients).

2.2.20 <u>Other types of risk assessment:</u> There are other types of risk assessment, but none widely used currently in violence risk assessment and so these will not be discussed here. The role of 'AI' (actually, machine learning, which is not quite the same) is being researched currently, which would be more akin to an actuarial method of risk assessment, which I will not go into further here.

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c) Are different types of tools used according to whether a patient is detained, in the community or subject to a CTO?

2.2.21 Actuarial tools should only be used on the population for which they have been developed and validated. Possibly outdated NICE guidelines (NG10) on violence and aggression reference two actuarial tools which were designed on inpatient and not community groups mentioned above which have some, but limited, empirical support and applicability in the UK. There are no widely used non-sexual violence risk actuarial tools of which I am aware that are developed and validated with those subject to a CTO or indeed in the UK, and therefore none which I am aware of that would be used with this specific population. Probation services have the OVP tool built into their OASys, but this was not developed for mental health patients specifically and while there would have been people who would come under the category of 'mental health patients' also under probation services in the group for which this tool was developed, an OVP score would not be calculated for a detained or CTO patient who is not *also* under probation services; OVP is not to my knowledge used outside of those being actively managed by probation. It would in my opinion in any case have some significant limitations in its use with those who could be considered 'patients' who are also under probation (and with whom the tool *could* be used), due to it not being designed for that group and likelihood of such people being in the minority in the development and validation samples. Therefore, reoffending statistics produced by OVP would be less comparable to that individual case than they otherwise might be.

2.2.22 For SPJ tools (of which the HCR-20v3 is one), there are no 'rules 'as to use on patients of different legal or restriction categories. SPJ tools therefore could be used across these groups (detained, community, and community CTO) provided the assessor deemed the tool's use applicable to that individual more broadly.

2.2.23 In summary, the *approach* used (i.e. actuarial versus SPJ) to assess risk in an individual case is not determined according to community versus inpatient status, or what sort of legal order or 'section' of the MHA (if any) has been applied. SPJ tools can be applied across all of these groups. Where violence risk is concerned, regardless of context, UCJ is generally considered inadvisable unless there is some exceptional reason that a tool

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cannot be used to guide risk assessment even in an adapted format (such as extreme time constraints). Actuarial tools may have exclusions to their use in some groups based on their development and manual guidance (e.g. some should not be used in inpatient settings as the tool and resultant statistics were developed for those sentenced to prison or probation and not a hospital order). SPJs have less rigid guidance and can be applied across inpatient versus community, and CTO versus unrestricted groups.

2.3 HCR-20v3

7. Please provide evidence in relation to Historical Clinical Risk Management Version 3. a) Please explain what this is – the questions involved; the process of using the tool; how long it takes etc.

2.3.1 The HCR-20v3 is an SPJ risk assessment tool. It consists of 20 'core' items split across 3 domains; historical 'H' (or 'ever'; 10 items), clinical 'C' (recent e.g. last 6 or 12 months to be specified by the assessor; 5 items) and risk management 'R' items (next 6 or 12 months to be specified by the assessor; 5 items). The assessor can also add in 'other' items not included in the core 20 items as needed, on a case-specific and flexible basis. These items are as follows in Table 1: each is rated on a 'not present', 'possibly/partially present' or 'present' basis. Each item is also rated for 'relevance' to risk, that is, is the factor contributory to violent decision making, and/or does it complicate risk management. Relevance is rated on a 3-point scale of low, moderate, or high. Rarely, items can be 'omitted' if there is no reliable information on which to base a view. If an item is 'not present', it should be rated as 'low' relevance. Each item has a detailed and specific definition to guide assessors; the 'headings' are not the basis of each item and the HCR-20v3 manual is very detailed.

2.3.2 Please see my response to instruction 11 below regarding the HCR-20v3 definition of violence, which is relevant to consider along with the process of completing the tool, which I summarise below.

2.3.3 **Table 1: HCR-20 items by domain.**

Historical (H) Items: Past (ever) problems with….
H1: Serious violence
H2: Non-violent anti-social behaviour
H3: Relationship instability
H4: Employment
H5: Substance misuse
H6: Major mental illness
H7: Personality disorder
H8: Traumatic experiences
H9: Violent attitudes
H10: Treatment or supervision response
Clinical (C) Items: Recent (timeframe to be determined by assessor, but typically last 6 or 12 months) problems with….
C1: Insight
C2: Violent ideation or intent
C3: Symptoms of major mental illness
C4: Instability
C5: Treatment or supervision response
Risk management (R) Items: Future (timeframe to be specified by assessor, but typically next 6 or 12 months) problems with….

R1: Professional services and plans
R2: Living situation
R3: Personal support
R4: Treatment or supervision response
R5: Stress and coping

2.3.4 The R items can be rated on an 'in' and/or 'out' basis, depending on whether the patient is detained ('in' = inpatient or prisoner, 'out' = community) and depending on where the assessor wants to consider risk in the next 6-12 months.

2.3.5 Practically, in terms of completing the assessment, assessors are required to follow the steps outlined in para 2.2.12 above and repeated below:

1. Gather information (information reasonably necessary to form an opinion)
2. Assess the presence of risk factors
3. Assess relevance of risk factors
4. Formulation violence risk
5. Scenarios of violence
6. Risk management planning
7. Opinions (e.g. likelihood, imminence, level of harm, other considerations)

2.3.6 The process is outlined in depth in the HCR-20v3 manual and training covers what is expected in more detail. The authors have, to assist users in following all steps, created a 'worksheet' or 'grid' that details each step that users can complete. Step 1 involves documenting sources and it is advised that a range of collateral information spanning all domains of a person's life are accessed, including documents (e.g. health records, police documents, social care, probation documents as applicable), liaison with professionals, interview(s) and / or observations of the patient, and liaison with personal contacts of the patient such as family members where applicable. For instance, records such as health / mental health records, previous convictions records and other police information where available, and the reports or verbal accounts of other professionals can be important. In terms of interviewing a patient, the length of

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interview will depend on what information is needed and also if the person is willing / able to be interviewed, but typically for someone 'well' I might plan in 4 hours of interview for a start and this may be enough, or it might not be. There is no specified semi-structured or structured interview schedule endorsed by the authors, as interviews should be individualised but the authors recommend planning some sort of semi-structured approach to interview. Clinical interview for violence risk assessment should draw on the professional's expertise and experience in their core profession e.g. psychology, psychiatry, nursing; this is why the professional having professional training and a background in individual assessment is essential. The interview and collateral information should aim to inform the assessor as to the history of the patient across domain, and should ideally help the assessor assess the more subjective constructs like 'problems with insight' and so some skill is required in this process. The assessor then uses all of the available information to 'code' the 20 (and any 'other') risk items for 'presence' of each item in the specified time period, and to consider 'relevance' of each item for future risk. This then leads into step 4, the clinical case formulation.

2.3.7 Formulation has its foundations in the psychology and psychotherapy literature and intends to help assessors conceptualise the causes / roots of the violence risk with a view to this informing intervention. This is not about simply listing risk factors that are present, it is about integrating risk factors by building on the assessment of presence and relevance, and turning this into a meaningful framework that attempts (as a hypothesis) to explain the person's violence. It tells a 'story' by integrating the information to help us make sense of the person's violence risk. There is no single theory of violence, and assessors have some flexibility as to what approach to use; I tend to teach the '5P' model of violence formulation on my training. This is based on Weerasekera's (1993) 'four P' model where the 'problem' (violence) is considered in respect of 'predisposing' (distal), 'precipitating' (proximal), 'perpetuating' (factors that maintain the problem), and 'protective' (factors that may support desistance from violence) factors. While formulation is a core element of training of many mental health professionals, for many other professionals who may complete the HCR-20v3, this step is one where training seems especially relevant / valued (within training in

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use of the HCR-20v3). This step helps the assessor understand 'why' the violence occurred, to inform the next steps, but it should be stressed that all formulation is a hypothesis.

2.3.8 The next step (5) of scenario planning can usefully be considered as formulation for the future, where assessors consider what the person might do in the future if they were to be violent, and why. It draws heavily on previous steps. Determining risk management strategies appropriate for a given case will depend on the risks posed by an individual; for this reason we need to consider 'what am I trying to prevent' or 'what am I worried this person might do'. These possible futures are generated by the assessor, and here one can see why this requires clinician expertise and experience, as it is not simply a case of 'joining the dots'. As briefly mentioned earlier, assessors are typically encouraged to consider these along the lines of possible 'repeats' (of previous forms of violence), 'twists' (which is where something about the violence has changed, whether motivation or commission), and 'escalation' (such as a worst case or lethal scenario). Scenarios should consider 'nature (what the scenario looks like e.g. likely victim, type of violence, motivation), severity (psychological / physical harm levels, chance of escalation to serious or life threatening), imminence (how soon, warning signs), frequency / duration (how often this might occur, chronic or acute) and how likely the scenario is. An 'improvement' scenario can also be considered, which is where the assessor might consider what non-violence or reduced violence might look like, and in the next step (risk management planning) what would need to be in place to achieve this. In expanding on this next step, risk management planning, this is where, based on each scenario generated, assessors are guided to consider, monitoring strategies (best way to 'see' risk is changing), treatment (what treatment or rehabilitation strategies are needed and are high priority), supervision (restrictions), victim safety planning (where possible, what can be done to enhance security of potential victims), and other considerations (such as what might increase or decrease risk).

2.3.9 The final step is where the assessor develops final opinions; the assessor is prompted to consider what level of intervention is needed to prevent further violence, what the

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risk of serious physical harm is if violence were to occur, how imminent violence is, when the case should be reviewed (routine or special), and if there are any other risks indicated.

2.3.10 Please bear in mind in reading the above, that 2 days of author-approved training is used by me to explain the background to this process and the steps, and also to practice the steps in a case study. Therefore, it is likely I have not explained these in a way which is easy to 'visualise' as this takes even experienced professionals working in this field some time to absorb and interpret. However, the authors' manual and the worksheet they have designed to aid clinicians' completion of the HCR-20v3, and training, assists users in the application of the tool. Please also note that in describing the tool I have relied both on my knowledge, experience, and also the HCR-20v3 manual (Webster et al., 2013).

2.3.11 On completion of the assessment, users can then consider their relevant decisions, or questions they have been asked, which will be based on the reason they have applied the tool. The tool in and of itself does not answer these questions, the user does, but in a much better-informed way.

2.3.12 My answer to how long the tool takes to apply in practice, unfortunately, is vague. This depends on the collateral information available, access to the patient and / or informants, and so on. Some cases have volumes of available information (although guidance is to consider what information is reasonably needed to form an opinion to rate the tool) which can be time consuming to filter through, and some cases have limited background information which can cause more time to be needed elsewhere to gather information e.g. patient or informant interview. Interview can take several hours across several sessions. In a more urgent case, this can be reduced, but the assessment would be more limited. Therefore, while I can't benchmark how long the HCR-20v3 should take, I can say it is hours and days (more likely days) rather than minutes and therefore, in comparison, takes much longer than UCJ and actuarial approaches. I typically complete detailed reports as part of my risk assessment practice, which also takes longer in terms of communicating risk, but the 'bare bones' of HCR-20v3 risk assessment can take a day to several days, including gathering

information and completing / writing the rest of the steps, outside of a detailed report.

b) Please consider the literature that supports the use of the tool. Please consider any literature that is critical of this tool.

2.3.13 There is so much research involving the HCR-20v3, that to attempt to summarise all of this in detail would involve a very lengthy essay if not a systematic review or meta-analysis. I have therefore provided an overview from existing meta-analyses. In essence, with a risk tool like HCR-20v3 it is not a case of literature supporting its use and / versus literature being critical of its use, rather, there are many studies examining its (usually predictive) value in various samples which can (and have) been incorporated into meta-analyses that attempt to summarise how effective (or not) the tool is.

2.3.14 Overall I would summarise that the tool may be effective in accurately assessing risk in some groups some of the time with moderate predictive accuracy being found in meta-analysis. Perhaps a more relevant question, on which there is very little literature (likely because measuring this would be difficult) is whether use of the tool actually decreases the likelihood of violence occurring in field-based studies (e.g. through good risk management influenced by the tool's use).

2.3.15 By way of some meta-analytic examples about predictive validity, Ogonah et al. (2023) found that the HCR-20v3 performed similarly to the actuarial VRAG in forensic psychiatric patients, with what can be described as overall a moderate level of predictive accuracy[7]. They concluded that for forensic mental health services, these findings suggest that as a minimum risk assessment tools should be used to complement clinical decision making (as opposed to dictating it). Singh et al.'s (2011) meta-analysis found median performance of the HCR-20 in predicting violence to be

[7] Area under the curve (AUC) is a common statistic calculated in research when assessing the predictive accuracy of risk assessment tools; Rice and Harris (2005) describe AUCs of 0.556 as 'small' effect size, 0.639 as 'moderate' and 0.714 as 'large'. The 9 individual studies included in Ogonah et al. (2023) showed AUCs ranging from 0.63 – 0.77. for HCR-20 in predicting violent recidivism with all studies having > 100 participants.

towards the higher end of the moderate range[8].

8. Which professionals/clinicians is the tool designed for and in what circumstances?

2.3.16 Professionals / clinicians: The tool is not designed for / to be used by one specific named profession, rather, it is designed for professionals involved in violence risk assessment more broadly. Typically, especially on the basis of the below quote from the manual, I would expect or at least encourage that users are qualified in a regulated profession (or 'in training' but supervised by someone in that profession who takes responsibility for the work) but this is not specified by the authors. In some cases, the user may not be qualified in a profession that is regulated by statute, but they may need to conduct violence risk assessment as part of their work. There may be limitations to their assessment if this is the case e.g. in assessing mental health-related items and they need to ensure that they act in accordance with the manual's guidelines on user qualifications. The manual does provide information about user expectations if the tool is to be used in legal decisions (which in the context of the current Inquiry may relate to, for example, if someone's mental disorder and risk to others is such that detention under the MHA may be a need). The below is an extract from the HCR-20v3 manual (p38):

"User Qualifications

Proper use of HCR-20v3 requires considerable professional skill and judgment. Accordingly, users should meet the following qualifications:

1. ***Knowledge of violence.*** *Users should be familiar with the professional and scientific literatures on the nature, causes, and management of violence.*
2. ***Expertise in Individual assessment.*** *Users should have training and experience in interviewing and the review of third party information (also known as collateral information or case history). Training and experience in the administration and interpretation of standardized tests would be helpful.*
3. ***Expertise in mental disorder.*** *Users should have training and experience in the assessment and diagnosis of mental, personality, and substance-related disorders.*

Users who do not meet the third qualification discussed above, expertise in mental disorder, may still use HCR-20v3 if they do one of the following:

1. *Assess risk factors related to mental disorder in consultation with or under the supervision of professionals who have the proper expertise and qualifications.*
2. *Assess risk factors related to mental disorder by referring to the results of previous or concurrent psychodiagnostic evaluations conducted by persons who have the proper expertise and qualifications.*

[8] Median AUC was 0.7, n = 1320, not exclusively psychiatric patients.

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3. *Assess risk factors related to mental disorder provisionally, document this fact, and discuss the importance of having their provisional assessments confirmed by those who have the proper expertise and qualifications.*
4. *Do not assess risk factors related to mental disorder. Document this fact. Discuss how the incomplete assessment limits opinion regarding risks.*

Note that the "requisite credentials" may vary across jurisdictions. As we discuss later, it is possible for teams of professionals to complete HCR-20v3. For instance, a psychiatrist or psychiatric nurse might complete ratings of items pertaining to major mental disorder, a psychologist might contribute by assessing items pertaining to personality disorder, and a social worker or probation officer might complete items pertaining to social history and future plans. In this case, it is important that an evaluator with expertise in mental disorder takes responsibility for the final ratings and decisions.

Use for Clinical and Forensic Decision Making

When HCR-20v3 is used for the purposes of clinical and forensic decision making-that is, decisions regarding the placement, treatment, or management of an individual-users should have a high level of knowledge and expertise (e.g., graduate or medical courses or other specialized educational training, supervised field experience) and should have the requisite professional credentials (e.g., be registered, licensed, or otherwise legally entitled to conduct risk assessments)."

2.3.17 Circumstances in which to use the tool: My response to instruction 7 details that the tool is designed to aid assessment of risk of interpersonal violence. The 'threshold' for using the tool in a given case comes down to clinical decision making of the assessor; the manual indicates that the HCR-20v3 can be used to assess risk of violence "when there is a legal or clinical need to do so" (p35). In respect of 'need', in some cases it is obvious that an assessment for violence risk is indicated (and thus obvious to a professional aware of the HCR-20v3 that this specific tool may be indicated), as the person could have a clear history of violence (convicted or non-convicted incidents) or has behaved in a way which makes the clinician reasonably seriously concerned about violence risk; there may also be concerns about mental state or instability that are clearly of concern. In other cases, it may be less clear (e.g. a vague, potentially threatening, statement made by someone with no violence history and no clinical concerns about mental state). In some cases, the use of the tool may not be indicated e.g. a case where someone has poor mental health, no history of violence and no clinical issues or behaviour that may give rise to concern about violence. It is certainly not needed in every case where someone has a mental health condition. Assessors with the requisite user qualifications discussed above, in principle, should be well placed to decide if an assessment is needed. If, however, a clinician is not particularly aware of the tool and is not trained in its use, they would of course not know the nuances of when it may be indicated to use the HCR-20v3, although clinicians can still

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spot a need to be concerned about violence risk and seek advice as needed (they would not necessarily need the knowledge of which specific risk tools to use, to be able to flag a need for violence risk to be carefully considered; for example they may see potential risk and consequently refer the patient to someone else for assessment).

9. Please explain the role of obtaining information from third parties – such as the police, probation, family or nearest relative of the patient – in utilising this tool.

2.3.18 The first step of completing the HCR-20v3 tool in a given case, as already mentioned above, is gathering information. More information may be (and often is) obtained or revealed during the process of engaging in the latter steps of the tool, which should be duly considered. The authors include in their manual that "ideally" the information base for the assessment would comprise various things which, relevant to this question, may include information from (or interviews with) collateral sources which include family members (and / or others known to the patient which may potentially, where appropriate, include past victims) and professionals who have worked with the person being assessed. This does not necessarily mean that speaking to all those involved is needed, as the assessor may have in their possession written information and reports from other professional agencies that provide the information needed to complete the assessment (e.g. PNC print of previous convictions / pending charges, probation reports, victim / witness statements).

2.3.19 The 'ideal' sources of information are listed below, but the authors do emphasise that the list represents an ideal situation and that in practice assessors "should attempt to gather reasonable information necessary to reach an opinion regarding risk in the case, given the context of the evaluation". This is because, in theory, the amount of information that can be gathered in a case is huge. The authors state that "Evaluators should balance comprehensiveness (gather all the information that is reasonably necessary) with efficiency (gather only the information that is reasonably necessary)." (p41) and that although there may be exceptions, the two primary sources of information typically necessary include all available and necessary file information, and an interview with the patient.

2.3.20 The interview is particularly important for capturing current functioning but this is also where other professionals' or family members' report of the person's recent behaviour is important, given that the patient may present differently to professionals during interviews or appointments due to fluctuations in their presentation, lack insight into their own functioning which affects the information they share, or indeed an attempt to appear 'less risky' through impression management which can be a huge issue in violence risk assessment. Importantly, the context of the assessment places limitations on the information that is (or can be) gathered and sometimes, for example in making immediate operational decisions or recommendations, assessors may have no choice but to rely on a limited information base, although assessors should recognise that the quantity and quality of information sets limits on the reliability and validity of their assessment. It is reasonable to say that a risk assessment is only as valid as the information on which it is based. Assessors need to make their own judgment as to any limitations, and whether they need to seek more information from collateral sources than is already available to them. The extract from the manual (p40) regarding 'ideal' information sources is cited below, although note that the manual has more to say about information sources:

"Gathering Information

To make judgments about risk for violence, evaluators need to gather information about the presence of, and changes over time in, the risk factors in the Historical, Clinical, and Risk Management domains.

Ideally, the information base for the assessment will comprise such things as:

1. Interviews with, observations of, and other information from the evaluee;
2. Interviews with or information from past victims;
3. Interviews with or information from collateral sources, including the evaluee's family members, friends, neighbors, and professionals who have worked with the evaluee;
4. A review of criminal justice records concerning the evaluee, including criminal records, police reports, transcripts of court proceedings, corrections records, and probation and parole logs;
5. A review of health care records concerning the evaluee, including physical and mental health assessment, treatment, and progress reports;
6. A review of education, employment, and social service records concerning the evaluee; and,
7. Psychometric or psychodiagnostic tests and assessment measures."

10. Further, as regards HCR-20v3, please explain how the following factors would or would not impact the assessment:

a. Sex of the patient;

2.3.21 For males, as most of the research underpinning the use of HCR-20v3 and the validation research is on males. While sex specific considerations can be made in the formulation (e.g. consideration of the aetiology of violence supportive beliefs may relate to male prerogative or masculinity for a person), no adjustments are required to the tool where their sex is male. Sex is not considered a 'risk factor' within the tool although as assessors are expected to be familiar with the literature on violence, they should be aware that statistically speaking violence is more likely to be perpetrated by men than women; of course 'being male' does not assist in the generation of risk management strategies. When using the HCR-20v3 with women, additional guidance can be considered to help the assessor consider factors that may link to risk specifically for women (e.g. Female Additional Manual [FAM]; de Vogel et al., 2014).

b. Age of the patient;

2.3.22 Age is not a risk item within the tool, which is designed for people aged 18 and above; where someone is at an extreme (e.g. 18 or just older, or an older adult) then this is likely to be considered within the formulation (for instance if younger there may be more of a focus on developmental factors and risk) and there may be age-related considerations affecting certain risk items (e.g. a person's risk management plans may be affected by them needing supported living if they are an older adult in need of such care). Item H1 ('history of problems with violence') guides assessors to consider violence history across the lifespan including developmental stages. Clinicians can also add in 'other' risk items to the HCR-20v3 as relevant and in younger people can consider whether any items included in the SAVRY (Bartel et al., 2006), which is a risk tool designed to assess violence risk posed by people under 18 years, may be relevant to include. Importantly, age and developmental trajectory of the individual can also be considered within the 'formulation' step of the tool. It is however not a direct consideration in terms of having a risk item of 'age' for instance.

c. Lack of compliance with treatment plans and medication;

2.3.23 This is captured at various stages of the tool; this would be captured in the H items at the least in H10 'history of problems with treatment or supervision response' and

would be relevant to discuss in H6 'history of problems with major mental disorder' (in terms of the impact of the issues on mental health presentation). It could be captured in the H5 'history of problems with substance use' item if the lack of compliance related to substances. It would also be captured in C5 directly (recent problems with treatment or supervision response), in C3 'Recent problems with symptoms of major mental illness' (in relation to actual symptoms exhibited), and likely also in C1 'recent problems with insight' (in relation to the person's understanding of the need for treatment and understanding of their mental health diagnosis) if this was a problem recently. In respect of the R items, it would be captured in relation to the assessor's rating of 'Future problems with treatment or supervision response'. These issues would be considered in the case formulation, scenario plans, and risk management plans, and would be highly likely to have an impact on the assessor's overall views on current risk.

d. Relapse when not taking medication;

2.3.24 The tool does not assess the risk of this occurring, as it is designed to assess risk of future violence. However, relapse when not taking medication would be considered as part of the overarching assessment in terms of, similar to my response to c) above, the problems with medication and treatment compliance. This should be taken into account in the formulation, scenario and risk management plans, and thus would feed into overall opinions on risk.

e. Insight or lack of insight;

2.3.25 'Recent problems with insight' is a risk item in itself in the HCR-20v3 within the 'C' domain. The item definition states that "This risk reflects current problems with lack of awareness, understanding or appreciation of one's violence-related functioning or the factors and processes that place the person at risk of violence." (p85). This is split into 3 dimensions including insight into mental disorder, insight into aggressiveness / violence, and insight into need for treatment. The item definition goes on to discuss this in more detail. If a person lacks insight into things that might increase or decrease risk, and lacks awareness of their own mental processing, then one can see how this

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may affect risk. For example, they may place themselves in risk-raising situations and may also fail to act to mitigate their risk, they may decide not to take medication when this may be needed to help manage risk in certain cases, they may not share risk-relevant information with supervisors and treatment staff members (which increases the need for collateral / informant information sources to supplement risk assessment), or they may fail to engage with support services as they don't consider they have any need to do so. Therefore, this risk item often relates to other items and problems (e.g. treatment compliance, substance use, breach of supervision) in addition to the 'recent problems with insight' item, and can also in many cases in my experience, increase the likelihood and imminence of risk. As with other risk items, these issues would be considered in the case formulation, scenario plans, and risk management plans, and would be highly likely to have an impact on the assessor's overall views on current risk.

f. Psychosis and schizophrenia; and

2.3.26 This is considered directly in risk items in the H and C domains of the tool. There is no assumption by the tool that in general all people with mental illness will be violent or are at higher risk, rather, the tool is based on factors that have been found to link to violence in people known or suspected to have been violent or aggressive in the past. These items can still be rated even if the person does not have a formal diagnosis and marked as 'provisional' rather than 'definite'; it is important to document the presenting symptoms and how they manifest for the person, as well as any diagnosis. If there has been a diagnosis, the relevant H item would be rated as 'present' and marked as 'definite' and if not, but it is suspected that the person possibly has (or has had, if they are not now symptomatic) a major mental illness based on available information, then the item could be rated as either 'possibly present' but marked as 'provisional', or it can be rated as 'present' if the evidence is very clear but marked as 'provisional' due to lack of formal diagnosis. If the assessor is a professional who can diagnose such a disorder (e.g. a psychiatrist), then even if there has been no diagnosis previously but they believe that the person is presenting with this illness, they may choose to rate this as present and 'definite'. As with other risk items, the impact on

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risk would be considered in the case formulation, scenario plans, and risk management plans, and current / recent mental health presentation would be highly likely to have an impact on the assessor's overall views on current risk.

g. Substance misuse.

2.3.27 There is an H item to prompt the assessor to consider past (ever) problems with substance use, and in the C and R items this would be captured indirectly e.g. it may relate to problems with insight, instability, treatment compliance, problems with living situation, and so on. Additionally, a person with substance use problems may be less able to engage directly in the risk assessment, depending on the individual's circumstances and use. As with other risk items, the impact on risk would be considered in the case formulation, scenario plans, and risk management plans (e.g. need for drug testing, possibility of substance use disinhibiting behaviour or exacerbating any comorbid mental health symptoms) and may affect overall opinions on risk.

h. History of violent offending, contact with the police or other information indicating previous acts of aggression, intimidation and violence towards others.

2.3.28 Having information detailing these features of the case is a critically important aspect of the assessment and influences the risk assessment in multiple ways. A history of the person's past aggression / violence, even if unproven / unconvicted, will contribute to and shape scenario and risk management planning. Assessors are guided to consider the person's violence history when gathering information. Their past violence is coded directly in item H1, and details of what happened directly feed into the formulation and importantly the scenario plans (where, as mentioned we may consider 'repeat', 'twist' and 'escalation' scenarios) to then form risk management plans and form a view of overall likelihood and imminence. If we do not know 'how' violence manifest in the past, we can't fully consider 'why' alongside the 'how' (i.e. formulate the case, consider our hypotheses about factors that were contributory to the person's violent decision making), and if we can't do this, we are somewhat blind to speculate about future risk. Type of violence, including patterns even if lower-level

violence, and severity should be considered. Where information on what happened in an incident of violence is unclear, or for example an allegation of violence is unproven with limited reliable evidence, this makes risk assessment more difficult as it is challenging for the assessor to 'weight' the information in their analysis.

11. **How does the tool define violence (or indicators of violence)? Does it include acts (including a history of acts) that may lead to injury of others without direct use of force (such as aggression or intimidation towards another that may necessitate that person to put themselves at risk of harm - eg: by escaping through a window or across a busy road)?**

2.3.29 The HCR-20v3 has a specified definition of violence as below, but it is stressed within the training that defining violence is more complex than one might think. The authors define violence as "actual, attempted, or threatened infliction of bodily harm on another person". It goes on to state that "Bodily harm includes both physical and serious psychological harm, so long as it substantially interferes with the health or well-being of an individual" and "psychological harm includes fear of physical injury, and other emotional, mental, or cognitive consequences of the act in question"

2.3.30 The tool is designed to assess risk of interpersonal violence only (i.e. violence towards other people) and is not designed to assess risk to self/suicide risk, or risk of non-violent general offending. Sexual violence, intimate partner violence, and stalking are types of violence that are covered within the tool's definition of violence, although there are other tools that are designed specifically for each of those forms of violence which may also, or instead, be indicated. Acts that cause primarily serious psychological harm would 'count' as violence e.g. threats to kill or other aggressive or threatening behaviour. Communications or behaviour that are merely expressions of anger or contempt, or that could not reasonably cause someone to experience fear of harm are not considered 'threats' here. Attempts at violence that are unsuccessful are included; e.g. an attempted murder that did not cause any physical harm would 'count'. The tool is not designed for extremism / terrorism / ideology-based violence risk assessment although may have some utility in such cases where the person also poses risk of general violence.

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2.3.31 The authors describe that the act, attempt, or threat must, to some degree, be deliberate or wilful (i.e. not an accident or a true reflex action). This means that the acts were intended to cause harm or were reckless as to causing harm, even if driven by psychosis as a relevant example. The legal concepts of culpability and criminal responsibility do not correspond directly to the definition of 'deliberate 'used by the tool, and when using the HCR-20v3 the assessor needs to use the tool's definition rather than legal ones; for instance, an act of violence for which someone was found not criminally responsible or to have had diminished responsibility, or for which they received a hospital order as opposed to a prison sentence, *would* typically fall within the definition of violence.

2.3.32 I do not have the full context of the example provided in the instruction regarding aggression / intimidation that may necessitate that the person (which I have taken to mean target / victim) put themselves at risk to avoid harm. However, if the behaviour described was threatening or aggressive I would usually consider it to be violence within the definition provided by the HCR-20v3. I would also consider the victim's response of self-protection to the person's behaviour (an extreme act to avoid harm) when making this judgment. I could provide a better view if I had the details of the incident, but it seems likely that this example would in my view be considered 'violent' within the HCR-20v3 definition. Even if the perpetrator's behaviour was ambiguous and not considered 'violence', then the HCR-20v3 would still allow concerns to be captured about this behaviour in various other risk items depending on the nature of it (e.g. it may be evidence of the C item 'problems with instability'; it may also be evidence of poor mental health captured in one of the H items and one of the C items; it may be evidence of 'other antisocial behaviour' captured in a H item; and what they did may have involved breaching a rule or order which would also be captured in relevant items; the perpetrator's view / understanding of the behaviour may demonstrate evidence for a C item of problems with insight). Overall, therefore, regardless of whether it met the definition of 'violence' within the tool, the behaviour would, if known to the assessor, be expected to be considered for meaning in relation to risk of future violence (likely captured in one or more risk item, and considered in relation to overall views on likelihood, imminence, and level of violence).

12. Does the risk assessment consider and/or differentiate between short-term and longer-term risks?

2.3.33 The tool is designed to be reviewed and repeated over time; there is not a specified timeframe, but a general useful guide could be that the higher the risk, the more frequent the review should be and the manual contains some recommendations for re-assessment intervals. The HCR-20v3 is not designed to 'predict' violence at an individual level, as has already been discussed, and it is not designed to be a long-term evaluation that does not need review. For example. the C items for 'recent' consider 6 or 12 months, and the R items for risk management consider the next 6 or 12 months, to help assessors form a current view, and therefore one can see even simply through passage of time how a risk assessment can be 'out of date'. However, in the sense that the tool considers future risk scenarios and imminence (that is, how much the risk is present and overhanging versus distant) of these future scenarios, and imminence of *any* violence is also considered overall in the final risk judgments, then it does prompt the assessor to consider shorter- and longer-term risks. The ability to consider imminence is an important feature of SPJs and allows assessors to consider, on a defensible basis, whether or not immediate action is needed in a given case. For example, the risk management plans for someone posing high likelihood of violence with low imminence, may differ from those for someone posing high risk with high imminence.

13. Does the risk assessment consider and evaluate the relationship between (i) the risk of an event occurring; and (ii) the magnitude of harm should the event occur? For example, can the tool identify an event that has a low or medium risk of occurring, but which would result in very serious/catastrophic injury?

2.3.34 The tool prompts assessors to consider likelihood of the scenarios generated, and also 'severity'. For each scenario the assessor is prompted to comment on: "What would be the psychological or physical harm to victims? Is there a chance of escalation to serious or life-threatening violence?", and when developing final opinions assessors are prompted to comment on "What is the risk that violence will involve or escalate into serious or life-threatening physical harm? (Low / Moderate / High)". Importantly,

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imminence of violence is considered for each scenario, and overall (e.g. "What is the risk that the violence will occur in the near future, for example in the coming hours to days or days to weeks? What preventative steps should be taken immediately") (Webster et al., 2013).

2.3.35 The issue of course with the above, is that not all possible scenarios will or can be generated even where the HCR-20v3 completed in a case is comprehensive and based on all relevant information. It is also the case that some people may present a high violence risk which does not map on well to available tools / the HCR-20v3, and that their risk is underestimated even when based on all relevant information. In such cases, an extreme act that they may then go on to perpetrate would not have necessarily been generated as part of the scenario process because it was potentially very different to what had been done previously, even where an escalation scenario is considered by the assessor. Typically, when considering future scenarios, the 'function' of past violence (i.e. what the person was trying to achieve / what motivated them / what 'needs' the act was meeting) will be considered. This is because it may be the case that where a person has in the past perpetrated lower level violence, they may be at risk of a much more severe act that serves the same function as their past lower level violence, in the future.

14. Does the risk assessment assist with identifying factors leading to the onset of psychosis?

2.3.36 The tool itself does not have this as part of the steps of completion, but indirectly assessors would usually consider this if psychosis is a feature of the case and if linked to risk. This is because, in rating risk items, and generating scenarios, assessors are asked to list 'warning signs' of increased risk. If major mental disorder in the form of psychosis had been identified as a risk factor, and had been a feature of at least one scenario plan, then typically a 'decline in mental health' may be listed as a warning sign and here, the assessor would have the opportunity to list any particular signs associated with increased symptoms of psychosis for that person whether causal / contributory, or something that is caused by the symptoms so it can be spotted. For example, these issues might be general and apply to many people experiencing mental

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health decline, such as 'non-compliance with medication' and 'non-attendance at appointments'. These may be warning signs that could be *contributory to increased symptoms* (therefore we should be concerned that a decline may be imminent) *or a result of mental health decline* already having occurred, but which if spotted could lead the team to consider that violence risk (likelihood and imminence) could be raised. Sometimes it is possible to spot (and therefore document) individualised indicators of poor mental health that have been observed in the person before (e.g. poor sleep, decreased interest in x [a hobby they enjoy], increased interest in y [something specific they have become preoccupied with when unwell in the past], growing a beard through not shaving when unwell), but this is not always possible. However, the tool is not designed to identify these factors in itself. There would be reliance on the user to consider this as being relevant to the case, and then to consider if any factors that may contribute are indeed observable. An assessor may also consider how other risk factors for the individual could link to decline in mental health / onset of psychosis e.g. if a person has a history of or current problems with cannabis or other drug use.

15. Please discuss any other features of HCR-20v3 that may be relevant to the subject matter of this Inquiry.

2.3.37 The HCR-20v3 is designed to assist risk assessment and thus help clinicians make wider decisions in a better-informed way; it is not designed to *dictate* what clinical / risk management decisions they should make. Such decisions go beyond use of any tool including HCR-20v3. It is designed to assist defensible decision making. I am unaware if VC had any risk assessment / HCR-20v3 in place. I am unaware of his history and whether having had a risk assessment in place may have resulted in these crimes being prevented through effective risk management. However, it is important to stress that even with a good (comprehensive, followed the structure of a tool designed to assess risk, considered relevant information) risk assessment in place, human behaviour is complex and cannot be predicted with high reliability. As already discussed, risk tools generally can be said to have moderate predictive validity and even then, this does not mean that they can identify someone who will progress from lower-level violence

to a multiple casualty spree.

2.3.38 Clinicians need to use the tools and information available to them as best they can, and accept the limitations of these tools. The HCR-20v3 assists with this process, but there is always the possibility that someone is assessed as high risk who may not be violent, and someone is assessed as low risk, who may go on to do something serious. Risk assessments including the HCR-20v3 are not perfect and also rely on the clinician's experience in suggesting and taking the appropriate action. Violence risk assessment is difficult, even where comprehensive tools are available. In 2012, a meta-analysis (Fazel et al., 2012) of violence risk assessment tool effectiveness summarised that even after 30 years of development, the view that violence risk can be predicted in *most cases* is not evidence based; although like any review and the research included in it, this meta-analysis will have some limitations, this remains an important message for the public who may have unrealistic expectations of risk 'prediction' at an individual level as they may expect (or at least hope) that risk assessment is more certain.

2.4 Your training programme

16. Please set out your role as the only certified trainer on HCR-20v3 in the UK.

2.4.1 I am an 'author-approved' trainer[9] and the only trainer delivering the authors' licensed training that I am aware of in the UK, with the process of 'training to train' and evaluation of the same being as described earlier in this report. There are likely to be other people who train others in HCR-20v3 (as discussed below) who may have been trained by the authors historically, as I am aware that the authors have provided training to organisations so that in-house trainers can train staff in the past. However, I am not aware of any other trainers in the UK who are licensed by the authors (Protect International). I offer and deliver open as well as closed (team) HCR-20v3 training events throughout the UK, with this moving from in-person to live online training during and post-COVID. I have found that numbers of people attending training since

[9] https://protect-international.com/services-3/train-trainer-certification-programs/

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delivery has been online has slightly increased, about which my hypothesis is that where location is not a problem this is easier for attendees to arrange both for their work and personal lives (practical), and also this is cheaper for individuals and services who then do not have to pay travel costs which would typically for many include a hotel cost as the training is a 2-day event.

2.4.2 I do not have any ongoing contracts for in-house / team training, rather, these are requested ad hoc by services. Most of the HCR-20v3 training I deliver is via open events rather than exclusive team events, and I tend to offer 2 open events per year (Spring and Autumn). By way of example of numbers attending the open HCR-20v3 training per year, I shall consider the last 2 years: in 2025 I delivered one Spring and one Autumn event both of which had around 50-60 people attending, and I did not deliver any closed training events in HCR-20v3. In 2024 I delivered 3 open events due to higher demand, again averaging around 50 people per training and no closed events. During both 2024 and 2025 I have provided fee quotes to several NHS trusts for closed HCR-20v3 training where they then did not take up the training.

17. Do others provide training? How widespread is such training provision?

2.4.3 Yes. Some companies offer training[10], typically delivered by psychologists. These vary in length compared to my training (for instance some are one-day events whereas mine is 2-day). I do not know what the content of their training is. The authors of the tool also offer pre-recorded training[11] and live online and in-person training (the latter mainly being outside of the UK). I am also aware that some NHS trusts task employed staff members to train other staff members in how to use the HCR-20v3. I am of the impression that employed staff members training other staff members in HCR-20v3 is reasonably widespread in healthcare services in the UK, and that organisations and individuals within them have developed their own training packages to support staff, but I do not know for certain how widespread that is and it may vary from trust to trust. I am not however aware if this occurs outside of forensic services; the only in-

[10] For example, https://tiofp.com/events/hcr-20-version-3-training-4th-march-2026/ and https://rockliffandscott.co.uk/hcr-20-v3-and-fam-training-1

[11] https://concept.paloaltou.edu/course/evaluation-of-risk-for-violence-using-the-hcr-20-version-3

house training for HCR-20v3 in the NHS that I am aware of has been within forensic services.

18. **How many professionals do you train per year? What is the percentage mix of professionals/clinicians? In particular, what percentage of your trainees are general psychiatrists, forensic psychiatrists, psychiatric nurses, forensic psychologists, other types of psychologists, lawyers (CPS or otherwise).**

2.4.4 I have provided figures above for the last 2 years (around 100 in 2025 and 150 people in 2024) for my HCR-20v3 training.

2.4.5 Almost all attendees have been professionals who would likely then use the tool in their work, and in the last 10 years of delivering HCR-20v3 fewer than 5 lawyers have attended. Having discussed this with the authors of the tool in the past, they would encourage legal professionals to attend for information purposes (i.e. not to use the tool themselves). It is my view that violence risk assessment has potential consequences for the person being assessed as well as public protection and other stakeholders, and that a high level of scrutiny is appropriate for such 'high-stakes' work, and that lawyers undertaking training would assist this process and drive high-quality defensible assessment processes even further.

2.4.6 Attendees range in profession and have included: psychologists (including trainees and assistant psychologists), psychiatrists (at various stages of career), nurses, occupational therapists, speech and language therapists, counsellors / psychotherapists who are not also registered psychologists, social workers, and probation officers. Some of these professionals in their practice would typically complete HCR-20v3 only as part of a clinical team rather than as a sole practitioner. Many are funded to attend training by the NHS trust in which they work, some (but few) NHS workers have self-funded, others work for private healthcare providers delivering commissioned services, and others in private practice. I am aware that some attendees have worked in both NHS and private practice. I have also trained research students who may use the tool in research and on occasion MSc-level forensic psychology students for educational purposes only.

2.4.7 I do not hold data on the professional discipline of all attendees although have logged this for some attendees. In relation to psychiatrists, I do not hold the data to confirm proportions of forensic versus non-forensic psychiatrists attending. I would reasonably say that it has mainly been forensic psychiatrists or those psychiatrists who may not use the title 'forensic psychiatrist' but who are working specifically in forensic services, who have attended. Some have attended who report working in learning disability / intellectual disability and / or autism services, where they may not be a forensic psychiatrist and this may or may not be a forensic specific service. I cannot recall an instance of a general psychiatrist not working in forensic services attending but this is entirely possible. I would say that the majority of psychiatrists attending are forensic psychiatrists or psychiatrists working in forensic settings.

2.4.8 In relation to psychologists, we generally have clinical, forensic, or more rarely but occasionally counselling psychologists attend training. I estimate that most of the HCPC registered qualified psychologists attending are clinical psychologists rather than forensic, which I am of the view relates to many forensic psychologists receiving training in HCR-20v3 as trainee psychologists before they qualify and thus not needing training once HCPC registered, as they are often already trained and competent. Indeed, we train lots of trainee forensic psychologists, and I cannot recall ever having trained a trainee clinical psychologist. Again, most of the clinical psychologists I train tend to work in forensic rather than general settings, or specifically for example a learning disability / autism team whose patients also present with forensic histories or risks but typically this has a 'forensic' service specification.

2.4.9 Given that many trusts will likely have their own in-house training, I do not believe that my experience as an external fee-paid trainer will likely give a good guide as to the types of professionals who receive training in HCR-20v3 across NHS services.

19. How long does the training take and what does it entail?

2.4.10 The HCR-20v3 author-approved training event that I deliver is a 2-day event running from 09:30-16:30 both days; a total of 14 hours including breaks and 11.5 hours excluding breaks. Training is not the only thing recommended to use the tool;

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attendees are informed to read the tool manual cover to cover, engage in practice and supervision / support, and also to keep up to date with key developments in this area of work/research; they are referred to the guidance in the manual on training which is detailed further in my response to instruction 20 below. On rare occasion in the past for closed team training, where I am satisfied that the team has some existing knowledge of risk assessment processes, the training has been shortened. Participants are informed of the need to use the tool in line with the manual in terms of their qualifications and competence, and also within their own profession's guidance, and to consider organisational policies and the law in addition to this.

2.4.11 The training is a mixture of 'teaching' new information (as interactively as possible), and 'practice' with case studies. The aims of the training are to build knowledge and skills in the HCR-20v3. Competency is not assessed; it is not a 'pass or fail' training course and attendees are referred to the manual and their own professional guidelines to consider the appropriateness of their use of the tool.

2.4.12 A general overview of content is below:

a) Key concepts (violence and risk assessment)
b) Actuarial and SPJ approaches
c) Violence as a decision (decision/action theory incl. brief case study)
d) HCR-20v3 development including overview of some related research
e) HCR-20v3 administration including case study (all steps, including detailed discussion of information gathering, risk items, formulation, scenario planning, risk management planning, and overall opinions; case study work is interspersed with the different steps e.g. teaching, practice, teaching, practice)

20. Can the tool be used without your training course? How user friendly is the tool without training?

2.4.13 Yes it can be used without my training, and indeed without any formal training programme. The authors provide the following guidance (p39)

"User Training

It is not required that qualified professionals who use HCR-20v3 complete a specific training program offered either by ourselves or other professionals, although such training may be beneficial. Adequate training can be accomplished in a number of different ways, including self-study, supervised practice, and attendance at lectures or workshops. We recommend that training include the following components:

1. A careful review of HCR-20v3 manual, with particular emphasis on basic information and administration issues.
2. A review of any critical advances in knowledge regarding violence or risk assessment subsequent to publication of HCR-20v3 manual.
3. Completion of file or file-plus-video practice cases.
4. Completion of actual cases under supervision of or in consultation with qualified colleagues experienced in the use of HCR-20v3

In our experience, the first two components of training likely require about 8 to 16 hours of study time, and the last two components of training require about another 8 to 16 hours. In sum, then, basic training in violence risk assessment using HCR-20v3 likely requires about 16 to 32 hours (about 2 to 4 days) of study time."

21. Are you commissioned by NHS Trusts or providers of NHS funded care to undertake training for whole teams or groups of teams? If so, how widespread is this commission practice?

2.4.14 I have been commissioned by NHS trusts to undertake training for whole teams in the past, but not in the last 2 years. I have however provided several quotes for this in the last 2 years which were not taken up by the trust. Sometimes trusts will place a whole team or several team members on an open training event (for example in the most recent training I delivered in October 2025, of over 60 attendees, one trust sent 9 people and another trust sent 9 people) rather than commission their own training event, which can be entirely appropriate and cost efficient. Within the Spring 2025 training event there were about 20 people from 2 different teams in the same trust who attended. Typically where it is a group booking, there are perhaps 3-6 team members who attend, about which my hypotheses would be that although this is not the full team, these people are those likely to take a lead on violence risk assessment in that team and they potentially support other non-formally trained people in their team to contribute to violence risk assessment in some way. As mentioned earlier, completion of the HCR-20v3 can take place as a team with a group of professionals completing it, or by a sole professional and in my experience in NHS forensic services the HCR-20v3 is more typically undertaken by the team with perhaps the psychiatrist or psychologist in that team taking the lead.

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22. Do NHS Trusts or providers of NHS funded care, as far as you are aware, fund the attendance of clinicians at your course? Or is attendance a matter for individual professionals to organise and fund?

2.4.15 Of those who attend our training from NHS trusts / NHS commissioned services, in most cases their service pays for their attendance. Some NHS professionals, more rarely, have self-funded, but they potentially may have claimed the costs back from the NHS and I would not be aware of this. Most self-funding attendees do not work for the NHS or NHS commissioned services. These professionals may work in private practice, for example.

2.5 Practice

23. Is risk assessment of violence to others, in your view, undertaken with sufficient regularity in clinical practice in the UK by professionals generally?

2.5.1 I can't answer this question fully as I do not have knowledge of all services in the UK. I am aware that in forensic services most trusts have internal policies and procedures on violence risk assessment and believe these are likely to be undertaken with sufficient regularity. I doubt violence risk assessment is 'regular' in non-forensic services but their need to undertake such assessment is likely to be lower, and they are less likely to have violence risk assessment trained / competent professionals in their team as a non-forensic service as a result of the nature of it, although that is not the same as saying there is not a need for this.

24. How is risk of violence to others assessed in practice? Are relevant tools used? To what extent do local NHS Trusts or providers of NHS funded care, to your knowledge, use HCR-20v3 or other risk assessment tools? Please provide examples.

2.5.2 In terms of how risk is assessed in practice, my response to earlier questions about the HCR-20v3 also answer this question. It is my experience that in inpatient forensic services, typically a violence risk assessment is completed on admission, and reviewed at least in line with care pathway meetings every 6 months if not before if the need arises. However, this may vary trust to trust. It seems likely that where an urgent

decision about an issue like detention in-the-moment is needed, that professionals would need to rely on UCJ due to time constraints, but where such detention relates to risk to others, I would expect a tool like HCR-20v3 to be used to help more comprehensively assess risk when time allows. I do not know if this occurs outside of admission to forensic services.

2.5.3 I do not know for certain, but it is my view that forensic services are likely to tend to use relevant tools to assess risk and to the best of my knowledge, the use of HCR-20v3 specifically is widespread in NHS / NHS-commissioned forensic services. In responding to this question about 'relevant' tools, for example, we also have professionals attending my more specialist sexual violence risk assessment training who are from many trusts (who tend to be psychologists and psychiatrists rather than other wider members of the team, as they may typically lead or complete these more specialist assessments themselves rather than a whole team approach, in my experience).

2.5.4 I do not know how regularly or appropriately non-forensic services assess violence risk, whether they use relevant tools, or whether they refer to their trust's forensic services (if the trust has them) for consultancy in this regard. I do not have all the facts, but VC's case gives rise to reasonable concern that there may not be sufficient training in, and application of SPJ approaches in non-forensic mental health services where these tools could reasonably (or 'need') to be used in given cases. This is however unknown for certain. I attempt to make recommendations below in relation to approaches that might help fill this potential gap.

25. Is there are disparity between Trusts/providers of NHS funded care and/or between general and forensic settings?

2.5.5 I do not know if there is disparity between trusts as to procedures but I think this is likely, especially in the absence of external or national guidelines / expectations regarding violence risk assessment.

2.5.6 I consider it highly likely that there is a disparity between violence risk assessment procedures / practice between forensic and non-forensic mental health settings. This may be a necessity as the structure and expertise of forensic versus non-forensic

teams will naturally differ, as will the regularity of the need for violence risk assessment.

26. What impact do the following factors play in assessment of the risk of violence and risk of offending:

a. Risks of failure to take medication, lack of engagement and relapse when not taking medication.

2.5.7 This would be considered within a risk assessment of violence in multiple areas; it is relevant to the rating of several items on the HCR-20v3 for instance, and would affect risk management plans as it is likely these issues go to imminence of violence risk for a person being assessed.

b. Insight or lack of insight.

2.5.8 See also my response to 10 (e). This would be expected to be considered in the HCR-20v3 in multiple ways and 'recent problems with insight' is a risk items within the HCR-20v3 in the C domain. This is not a risk item in any actuarial assessment of which I am aware, and as such cannot be considered in that type of risk tool. However I would expect a clinician with knowledge of mental health, and some knowledge of violence, to clinically consider the impact of this issue on risk even if not completing a HCR-20v3, and although this relies on some knowledge and experience, I would expect a professional who is regulated by a statutory body to be working at this level.

c. Consideration of a patient's immediate presentation as well as their history, including acts of aggression, intimidation, history of violent offending or contacts with the police.

2.5.9 This is central to violence risk assessment in my opinion. As mentioned, actuarial tools would only consider one aspect of this (history of aggression) and even then, an actuarial tool might not capture violence that has not resulted in charges, and would not consider immediate presentation, but the clinician could do so. This could all be taken into account in an SPJ approach, and if imminent in-the-moment decisions need to be made without time for an SPJ, I would expect a clinician who has to make an UCJ

to consider both immediate presentation and history in doing so.

d. The patient's expressed wishes as to their care, including where these conflict with views of clinicians and/or their family.

2.5.10 It is considered best practice to listen to the patient's expressed wishes and incorporate these into violence risk assessment where possible. Indeed, co-production in violence risk assessment is a growing area of discussion (e.g. Roberts & Young, 2025) but it is commonplace in violence risk assessment a patient's wishes may conflict with the opinions of family and clinicians (e.g. a proposed medication regime) and also with what is *necessary* for public protection. I can't speak to the legalities of imposed medication regimes or detention under the MHA as I am not an expert in those areas and only have working knowledge. However, within risk assessment, the focus is on violence prevention / minimisation of risk, and risk assessment is not just about 'doing the right thing' for violence risk, but is also about 'being seen to do the right thing' in making defensible decisions that carefully consider the rights and wishes of the patient, and public protection. Therefore, an evidence-based risk assessment can help the clinician consider all views including the patient's but the clinician then needs to decide, on the basis of risk, what might be necessary for violence risk management even if this is against other stakeholders' wishes, including the patient, and they need to document this accordingly. The HCR-20v3 assists clinicians in weighing up this evidence and focusing on risk management.

2.5.11 I must however add to this that there are frameworks in place under the MHA to safeguard patient rights in making anything 'mandatory' (detention, treatment order) that psychiatrists can use. It is commonsensical to say that if a strategy was deemed essential or necessary to manage violence risk but is not wanted by the patient and is not actioned, then risk is likely to be high. The problem of course lies in whether or how something is deemed 'essential', and then legally whether anything can be done where the patient disagrees. Carefully considered risk assessment can help in such determinations.

e. Treatment based upon positive risk management principles including reluctance to

use diagnostic labels because of the potential adverse impact on a patient's long-term prospects.

2.5.12 This would have an impact on violence risk assessment, dependent on how this affected recording of information, and treatment approaches. For instance if the risk assessor sees in the records that the person has no diagnosis, and if the assessor does not have information relating to presentation that might suggest symptoms are present and significant even without diagnosis (as symptomatic presentation can be taken into account in an SPJ without diagnosis), then this potentially important feature of their case and risk may be missed, resulting in deficient risk management plans. If lack of diagnosis (where the person has the mental health problem) results in lack of treatment and support, then this may perpetuate or even increase risk of violence. If someone was well now, but in the past has had symptoms that did not receive a diagnosis (when they did have the illness), then the magnitude of symptoms and their potential importance to risk may more easily be missed as the clinician assessing risk may not have the full picture. Again, I wish to caveat that I am not an expert on the MHA, but it is *possible* that lack of diagnosis may mean that certain provisions of the MHA cannot be applied in a given case. Positive risk management principles in relation to violence risk are not necessarily a bad thing so long as effective risk assessment and management principles are not undermined. It is of course possible that this approach in some circumstances can undermine effective risk management, especially if it affects communication about potential risk factors and level, and treatment provision.

f. Avoidance of restrictive practice and approach in the context of concerns about disproportionate overuse of Mental Health Act restrictive measures with Black African and Black Caribbean patients publicised in the context of Mental Health Act reform.

2.5.13 All cases of violence risk should be viewed from a 'least restrictive' risk management approach that protects patients' rights, regardless of race/ethnicity. Practitioners should approach cases in a way that is sensitive to diversity, but they must not lose sight of the purpose of violence risk assessment, which is to prevent violence through assessment and application of proportionate risk management strategies. The

necessity of potentially imposing approaches that may be against the patient's wishes as part of risk management recommendations should ideally be made based on the assessment of nature, likelihood, imminence, and potential severity of future violence and on an individual basis. If a necessary risk management strategy is not being imposed because of wider concerns about overuse of restrictions, rather than on the basis of the individual's risk to others, then it follows that risk may not be effectively managed. That is not to say that clinicians should not be conscious of wider concerns about overuse of restriction in any sub-group or indeed that black men are disproportionally represented at all stages of the criminal justice system. Risk tools like the HCR-20v3, within the clinical case formulation step, allow flexibility to consider any impact of race / ethnicity on the trajectory of that person's violence risk. However, decisions about risk management strategies should be based on the individual person's violence risk. Peer supervision when completing risk assessments more generally, which can provide a space for reflection on considering diversity related issues, may assist in ensuring that risk management strategies remain proportionate while protecting the public.

g. Resourcing of mental health provision including forensic assessment of risk.

2.5.14 Resourcing of both mental health provision in cases where there is or may be risk of violence, and resourcing forensic risk assessment has a huge impact; if there is no resource for risk assessment then risk management plans are likely to be deficient and risk may not be addressed, and if there is no resource for mental health treatment where this relates to violence, said violence risk is not being reduced / managed proactively (if at all).

2.6 Recommendations

27. Do you have any recommendations to make to ensure best practice when assessing the risk of violence posed by mental health patients?

2.6.1 I do not have recommendations over and above what is generally considered best practice in, for example, the application of SPJ tools when properly applied. I would say that training is advisable both because risk assessment is complex, and

importantly to increase clinicians' confidence in using these tools when there is a need. Continued professional development including, keeping up to date with relevant literature, 'refresher' training if needed, and peer or team supervision to help in complex cases and also to avoid 'manual drift' (where people drift away from the item and tool definitions and use it in a way that is not in line with its design) is strongly advised.

2.6.2 I am unaware if Mental Health Review Tribunal (MHRT) panel members in non-forensic MHA detention reviews are expected to have formal training in understanding or completing violence risk assessments, in order to aid their decision making. I think that this is important to consider for specialist (e.g. psychiatrist) panel members. I would assume panel members in forensic cases (i.e. people detained under a forensic section of the MHA) do have such training or forensic backgrounds, but am not certain; this too is important to consider, in my opinion.

2.6.3 As mentioned earlier, use of any structure is better than no structure at all in assessing risk and this premise applies to mental health patients where violence risk is indicated as a possible concern.

28. Are there areas relating to assessment of risk to others in which you consider that there is a need for:

a. National training and/or guidance where there is none?

2.6.4 NICE guidelines for the prevention and management of aggression and violence (NG10) are being updated. It is my view that these should provide guidance specifically for non-forensic teams on violence risk assessment e.g. consideration of use of an SPJ or other appropriate tool (which I don't think should be mandated in the guidance but examples could be given), or where there is no staff member who can apply such a tool, there should be a strategy for obtaining violence risk assessment e.g. consultation with other teams in the trust who have this experience / training.

b. Greater training and/or guidance than already exists?

2.6.5 As mentioned above, NICE guidelines for the prevention and management of

aggression and violence (NG10) are being updated but have not been updated for 10+ years. There is an argument, given the consequences of violence, that these should be updated more regularly, for example every 5 years, which would allow time for the development of the research literature in this area.

2.6.6 It is my view that NICE guidance should provide guidelines and recommendations specifically for non-forensic mental health teams on violence risk assessment (e.g. that they should consider of use of an SPJ or other appropriate tool, I do not think that an exact tool should be mandated in the guidance but examples could be given), or where there is no staff member who can apply such a tool, that there should be a strategy for obtaining violence risk assessment e.g. consultation with other teams in the trust who have this experience / training.

2.6.7 Trusts are likely to have their own policies on violence risk assessment. If they do not, then in my view they should. This is where they can operationalise any NICE guidelines and other empirical evidence about violence risk in light of analysis of the needs within their own services, other local services, and patient group.

2.6.8 I would caution that guidelines and policies risk being too prescriptive. There may for instance be good reason that a certain risk tool is not applicable in a certain case, and timescales for review should be individually planned for in addition to perhaps general guidance on a 'routine' review. Guidelines should also consider that comprehensive violence risk assessment takes time and therefore is costly to resource both in respect of training and clinical practice. The fact that not everyone with a mental health diagnosis will require a violence risk assessment should be a clear consideration, but (non-forensic) services should be prepared and equipped to conduct such assessments when clinically indicated and this should be considered within any guidance. In my experience, violence risk assessment is, and in my view should be, routine within forensic mental health services. This case of VC highlights the need for strategies for effective violence risk assessment practice in non-forensic services.

c. Changes to the current structures, training, or guidance to reduce the risks posed by psychiatric patients to others.

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2.6.9 In line with my response to b) above, I am of the view that ideally in non-forensic mental health teams there should at least be a professional who is the violence risk lead, who is able to complete violence risk assessments or that there should be a clear pathway within every trust for obtaining violence risk assessments for patients in non-forensic services (such as funding for consultancy from the trust's forensic services, or a neighbouring trust if a trust does not have any forensic services). This is likely to have resourcing and cost implications. Trusts should have a plan as to the provision of risk assessment training within their forensic and non-forensic services.

29. In your view:

a. Should the use of risk assessment tools be standardised between Trusts/providers of NHS funded care?

2.6.10 I think that standardisation so that trusts / providers do exactly the same thing in all cases has risks associated with it in terms of the fact that people are individual, and the need for a risk assessment and (if needed) what sort of risk assessment will vary from person to person. I do not think that guidance should dictate which tool is used, where one is indicated, and this should be left to clinicians, perhaps in line with generalised national guidelines (which are guidelines and not 'dictations'). However it is my view that there should be guidance that tool selection must be based on current empirical research and clinical practice (for example the HCR-20v3 is currently the most widely used and researched violence risk tool that is, as far as such things can be, reasonably well validated across populations, but that could change).

2.6.11 In my opinion, what should be standard however is that each trust has a policy for non-forensic services with procedures for considering if a formal risk assessment tool is needed in a given case, and pathway to obtaining one. That will not help with 'in the moment' decision making (e.g. when a psychiatrist is faced with a patient acutely unwell with possible imminent violence risk and they need to decide on whether to detain under the MHA at that moment) but will help with violence risk assessment and management processes more broadly. This process described would not be cost neutral if there is currently no (or limited) provision for patients to have a violence risk

assessment in the non-forensic service. Forensic services are likely to already have local policy on violence risk assessment, but if they do not, they should have.

b. Should the use of risk assessment tools be mandated, or more strongly encouraged, in clinical practice?

2.6.12 Based on the above discussion I am of the view that it should be more strongly encouraged and not mandated, but that what should be mandated are adequate procedures to consider if a person requires a formal risk assessment tool to be used and how this can be obtained.

30. To the extent not already covered, what recommendations do you think the Chair of this Inquiry should make to ensure lessons are learned and to prevent similar attacks in the future?

2.6.13 Consideration should be given to funding in other aspects of the justice system where professionals can provide risk assessment. For example, consideration could be given to the need to provide funding and resources for police forces to have access to an expert psychologist in risk assessment (typically a forensic or clinical psychologist) who they can request to complete a violence risk assessment where indicated in a case about which they have particular concern. This may prove especially valuable in cases where a person comes into contact with police for lower-level violence, about whom there are concerns, and they are not under mandatory (or any) mental health treatment, and/or they are being cared for by non-forensic mental health services and may not have a risk assessment in place.

2.6.14 This may also help in cases where the person does not have a mental health condition / is not known to mental health services at all, but they have had some concerning contact with police. These people may not have any follow up via mental health services, and may not already be under probation, but may be on an escalating risk trajectory.

2.6.15 While mental health professionals (NHS or NHS commissioned services) which may or may not include SPJ risk assessment trained professionals are often attached in some

way to a police station in terms of liaison and diversion, this is limited to mental health (therefore those without such conditions who may pose a risk fall into a gap) and to my knowledge in any case it is not the role of the liaison and diversion service to provide a detailed SPJ risk assessment even for those presenting with a mental health condition. It would in my view be relevant to consider a police-employed (or police commissioned independent) psychologist who has risk assessment expertise, to fill the identified gap. There are to my knowledge no such services currently, and this could help prevent single homicides or multiple casualty attacks whether or not mental illness-related.

2.6.16 In summary, lower-level violence-related contact with the police can in some circumstances be a warning sign of an increasing risk trajectory and there are currently people who slip through the gap by having no risk assessment whether or not their case relates to mental illness (e.g. I am aware of another high-profile case of multiple murder whereby the perpetrator had contact with police in the lead up to the mass casualty event and I believe they were not under mental health services, and it is reported that VC had such contact too). Whether or not my recommendation about having a police-attached risk assessment specialist psychologist will *prevent* violence in the future in such cases, or would have done so in VC's case, will never be known. For some people, the severe escalation of their offending would never reasonably be hypothesised at the time of risk assessment and risk tools are no guarantee of accuracy (as is discussed in more depth earlier in this report) but I do think my suggestion would help fill what appears to be a potential gap. This lends to a few wider issues such as; what next for the person if they are not engaging with or subject to services; what if they need an intervention that is not available to them via services; how would a psychologist working for or commissioned by the police access information from other services (e.g. health / NHS, school / university where relevant, probation, prisons, social services, employers of the individual, family) especially in the absence of consent from the person being assessed. There would need to be a legal framework and ease of access to information.

31. What improvements could be made locally and nationally to multi agency working

to increase effectiveness in preventing similar outcomes in the future?

2.6.17 Serious case reviews often reveal deficiencies in information sharing between services. I have had this experience myself when working across agencies. I provide here some personal examples I have experienced but am aware of countless similar other stories from people doing a similar job to mine.

2.6.18 In one case I was involved in on behalf of the police where I was completing a violence risk assessment, I struggled to obtain relevant information from probation services and faced barriers and delays although did eventually receive it. The same occurred in a case I was involved in for a risk assessment ordered by the family court, where the probation services would not provide the information requested to inform the risk assessment, and the relevant professional simply refused to discuss the case with me, even though the person consented, after taking what was described as 'data protection' advice. When working in prisons completing risk assessment, in one case the healthcare provider (NHS commissioned) failed to even respond to requests for information with the patient's consent. It is also usual practice in prisons that relevant health records are not shared with non-NHS staff members (i.e. prison employed staff members) without the patient's consent (and in many cases involving serious risk, the patient may not consent) and these are kept on different systems. In another case, health records were provided to me by a commissioned prison healthcare provider with the consent of the patient in a court-ordered risk assessment but were provided in a format so redacted that they were effectively useless. The healthcare provider had redacted all past entries that their own employed staff members had not made, stating that they could not share other aspects of the health record, but leaving me with no clue as to what trust to try to contact to gain redacted information (the entries made in the past, and by other trusts). In many family court risk assessment cases, despite a general request for the full record with the person's consent, the GP health records are inexplicably provided with selected words redacted which one can work out, as a best guess, are words related to mental health like 'anxiety' or 'self-harm' which are likely to affect risk assessment. I provide these examples to highlight that even now in 2025, despite multiple findings of the need to share risk-related

information in serious case reviews, obtaining information legitimately sought to help assess risk is a challenge.

2.6.19 Some of the above issues relate to data protection practice (regardless of consent of the patient), and some relate to consent of the person for information sharing between agencies. These problems pose legal and ethical dilemmas to which I do not have the answers, but ultimately information sharing between agencies when it comes to risk assessment remains problematic and could result in missed information that affects risk assessment in a serious way.

2.6.20 In health and justice settings it is my view that emphasis should be placed on the duty to share for public protection and safeguarding (not limited to identifiable vulnerable adults / children) and that the DPA should not become a barrier to sharing information that is required to assess risk of serious harm; this should in my view be incorporated into staff training and policies throughout the health and justice systems. Policies should be in place about information sharing between agencies with a special focus on cases that do not meet the threshold for MAPPA/MARAC. It is my experience that where there is a barrier to information sharing, it has been the case that professionals are often more afraid of sharing information and 'getting into trouble' than the (potentially lethal) consequences of not doing so. The Caldicott (UKCGC[12]) principle of *"An individual's information may be shared if it is believed that it is necessary to prevent or reduce the risk of serious harm to themselves or others."* should be emphasised and stressed as part of mandatory data protection and risk training in health and justice services, in my opinion. There should be some way of making information sharing between agencies more reliable, efficient, and useful. Staff members should be empowered by their employers to act on principles of risk management when it comes to data sharing. Some of this may come down to legislation which again I am not expert in, but these barriers to information sharing may result in unintended lethal consequences.

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[12] https://www.ukcgc.uk/news/blog-post-title-one-b53dd

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Weerasekera, P. (1993). Formulation: A multiperspective model. *Canadian Journal of Psychiatry 38*(5), 351-358.

Woods, P. & Almik, R. (2002). The Brøset Violence Checklist (BVC). *Acta Psychiatrica Scandinavica, 106*(s412) 103-105

3 Appendices

Appendix I: CV

Dr Ruth J. Tully, Consultant Forensic Psychologist

BSc(Hons), MSc, DForenPsy, CPsychol, EuroPsy, FBPsS, CSci, MAE, AFHEA

Academic Qualifications

Doctor of Forensic Psychology (*The University of Nottingham, 2012*)

MSc Forensic Psychology and Crime (*Coventry University, 2010*)

BSc(Hons) Psychology and Counselling Studies (*University of Derby, 2005*)

Professional Qualifications, Memberships, and Titles

Chartered Psychologist, Fellow, and Full Member of the Division of Forensic Psychology: *British Psychological Society (BPS)*

Registered Forensic Psychologist: *Health and Care Professions Council (HCPC), PYL29136*

Registered EuroPsy Psychologist: *European Federation of Psychologists' Associations (EFPA)*

Chartered Scientist: *Science Council*

Full Practicing Expert Witness Member: *The Academy of Experts (TAE)*

Associate Fellow: *Higher Education Academy (HEA)*

Expert Witness Certificate (Criminal, Civil, & Family Law): *Cardiff University/Bond Solon*

Registered Qualified Psychometric Test User (Forensic): *BPS*

Registered Psychology Practice Supervisor: *BPS*

Associate Professor (Hon): *The University of Exeter*

Current role

Tully Forensic Psychology Ltd: **Clinical Lead & Director, Consultant Forensic Psychologist**

At Tully Forensic Psychology we provide clinical and expert witness services in a range of forensic contexts. I am a Consultant Forensic Psychologist, having been externally validated as a consultant. I specialise in forensic psychology, having worked in this field for 19 years. One particular area of expertise lies within the field of risk assessment of a variety of risk types including sexual offending, violent offending, and terrorism / extremism / ideology-based offending. I have been involved in the risk assessment, management, and treatment of such risks in prison, healthcare, and community settings. I specialise in criminal court and parole assessments, and in the assessment of people (primarily adults) involved in care proceedings/family court. I have significant experience in assessing complainants and victims, for instance in the assessment of trauma, cognitive ability, memory functioning, and in making recommendations for adjustments / support needed to give their best evidence instructed by various police forces across the country.

I was awarded the BPS Division of Forensic Psychology Junior award 2013 for *"notable contribution to the field of Forensic Psychology"* and was awarded EuroPsy status, an international registration, in 2014. I am a Fellow of the BPS, awarded 2024, which is the highest title a member can earn, given in recognition of significant contributions to the advancement /communication of psychological knowledge and practice. I achieved my first Consultant role working in a private hospital as a senior manager and Consultant Forensic Psychologist. I now supervise a team of approx. 45 expert psychologists (forensic, clinical and neuro- psychology experts), as well as one speech and language therapist. I am neuropsychology lead in the service, with a particular interest in forensic aspects of neuropsychological assessment. I have also been contracted to provide clinical supervision for Psychologists and trainee Psychologists working in various settings e.g. child sexual abuse/exploitation and residential children's homes (working with victims and perpetrators). As a team we provide clinical and expert assessments in a variety of contexts, as well as psychological treatment, supervision, training, consultancy, and research and I oversee the work of the whole team of psychologists, consisting of senior

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and consultant level psychologists. I have completed and/or supervised in excess of 2000 forensic risk assessments. In 2022 I gave invited evidence to the Parliament Science and Technology Committee on the evidence used by The Parole Board of England and Wales. In 2023 I was appointed as a forensic psychologist panel member for HCPC fitness to practice cases where I have heard investigating committee and interim order cases. In 2025 I received a Judicial Commendation for "exemplary reporting" in the sentencing process of a complex case involving risk and personality assessment.

I am a regular speaker at national and international conferences and events. I also am an invited expert to speak on the TV and radio news (e.g. Sky News, BBC news) as an expert in my field, and I advise on media projects such as documentaries and dramas for TV. As well as my skills in psychological assessment and treatment, I have extensive knowledge of operational and procedural issues in prisons and other areas of the justice system including criminal and family law, having completed the Bond Solon/Cardiff University certificates in criminal, family, and civil law as well as having written many expert witness reports across these areas. I have worked with males and females across the lifespan (child to older adult), as well as high-risk sexual and violent offenders whose convictions/allegations include arson, rape, murder, stalking, terrorism offences, and organised crime, as examples of serious offences. I am also skilled and experienced in working with people with less serious offences, no offending history, unproven allegations, or child neglect / psychological harm. I am trained and experienced in the highly specialist area of assessing risk of violent extremism offending or other ideology-based violence / offences e.g. VERA-2R. My criminal and parole work has included high profile cases, and I have been instructed by parties such as by the prosecution (CPS and Police), defence solicitors, military police/prosecutors, local authorities, private and public sector prisons, insurance companies, religious organisations, and sporting bodies. In family cases I have been jointly instructed for cases in proceedings, and I have completed many pre-proceedings assessments. I am highly competent at giving evidence clearly and assertively in various formal and less formal settings. I provide expert advice and assessment to police forces at various stages (investigation including cold cases, prosecution, post-sentence) regarding complainants/victims and defendants/suspects.

I am an author-approved trainer of the HCR-20v3 violence risk tool, the SARAv3 intimate partner violence risk assessment, and the SAPROF protective factors assessment. I have now trained several thousand professionals in these and other risk tools such as RSVPv2 (sexual risk tool) and SAMv2 (stalking risk tool), nationally and internationally. I remain active with research, being an invited peer reviewer for respected academic journals, and having published papers in many respected peer reviewed journals as well as written book chapters, and I have edited several books. I am an invited speaker at conferences as well as an invited external doctoral thesis examiner for various universities. I have served on the editorial board as Associate Editor of the peer reviewed journal, Frontiers in Psychiatry. I hold the honorary position of Associate Professor at the University of Exeter where I am involved in the training of their doctoral forensic psychology trainees.

I assess a wide range of mental health, trauma, personality, neuropsychological, autism/developmental disorder, and risk related presentations by psychometric assessment, clinical interview, and forensic analysis of the evidence. I have expertise in forensic mental health (acute and slow-stream long-term wards), 'personality disorder', learning disability, autism, addictions, and risk. I am experienced in risk assessment, sex offender treatment, and violence reduction treatment (e.g. anger management) across settings. I therefore have the advantage of being able to apply my knowledge and skills across these settings, such as when working with people whose forensic history means that they have come into contact with prison/probation and healthcare agencies. These can be people who may be neglected and 'stuck' in the prison system, or situations where the Court may not know what to recommend for a person without expert advice. The input I have provided in family cases has assisted decisions about contact and placement of the child/young person. I am experienced in assessing those who have no proven offending but about whom there are related concerns or allegations, and in assessing a parent's risk or protective capacity for family court.

Summary of Clinical Experience

- Provision of psychological assessment and therapy to individuals with enhanced rehabilitation needs linked to mental health, personality disorder, learning disability, substance misuse, and risk in a variety of settings including prisons, community, and secure hospitals.

- Conducting therapeutic interventions drawing on varied models e.g. EMDR, DBT, CAT, CBT, CFT, ACT.
- Clinical and managerial supervision of Psychologists and other multidisciplinary team members e.g. senior Nurses, CBT therapists, psychotherapists, art therapists, drug workers.
- Delivering training and providing consultation to multi-agency professionals.
- Designing, implementing, managing, and evaluating service development projects and audits.
- Recruitment/management of staff and service development.

Employment History

2012 -Present: Tully Forensic Psychology Ltd

Consultant Forensic Psychologist, Clinical Lead and Director

- Clinical and expert witness psychological assessments e.g. risk, learning, & personality assessments for defence, prosecution/statutory body, Court ordered, and as single joint expert. Psychological services in clinical settings e.g. NHS, local authorities, children's homes.
- Report writing and oral evidence; assessment and treatment of people who have offended and victims.
- Training professionals, consultancy, and research services.
- Supervision of a team of 45 forensic and clinical psychologists within the company, as well as a Speech and Language Therapist with input to family, criminal, prison, and immigration cases.

November 2023 – Present: University of Exeter

Associate Professor (Honorary)

- I provide input to the DForenPsy, which is a doctoral training programme leading to eligibility to apply to become a HCPC registered Forensic Psychologist.

June 2023 – Present: Health and Care Professions Council

Partner, Fitness to Practise Panel Member (part time/sessional)

- I am a HCPC Partner, working as a registrant panel member for fitness to practise cases. I consider information and evidence to come to a well-reasoned and fair decision on registrants' fitness to practise cases as part of each panel. My experience to date has included investigating committee, interim order review, and interim order application panels in complex cases/allegations.

June 2014-November 2016: The University of Nottingham

Assistant Professor (part-time)

- Training and providing clinical and research supervision of Doctoral level Forensic Psychologists e.g. with young people at risk of offending.
- Designing and conducting forensic research, teaching statistical analysis and psychometric testing. Responsible for BPS/HCPC accreditation processes.

March 2014 – July 2014: Priory Hospital, Nottingham

Consultant Forensic Psychologist (part-time)

- Service development and senior management of new site offering addictions and acute mental health services to male and female inpatients.
- Preparation and development of hospital-wide programme of therapeutic rehabilitative activities, alongside working with commissioners regarding contracting and planning of bespoke services. Managing a team of specialist therapists (addictions, art, psychotherapists, CBT).

December 2012 – March 2014: Nottinghamshire Healthcare NHS Trust, The Wells Road Centre, Low Secure and Community Forensic Directorate

Forensic Psychologist (full-time)

- Specialising in the assessment and treatment of detained patients with a range of complex

needs including mental illness, personality disorder, developmental and learning disability. Provision of rehabilitation programmes with individuals and staff teams. Trainer/consultant to the multidisciplinary team and supervision of staff.

- Role involved low secure, step-down, and community setting with male and female patients.
- Designed and developed sex offender and fire-setting treatment interventions for the LD secure forensic ward including patients with developmental disability e.g. Autism.

2006 -2012: Range of prison (HMPPS), secure hospital, and community forensic NHS settings

- Forensic Psychologist in Training/Psychological Assistant/Group Work Facilitator/Supervisor. Working with adults and young offenders (e.g. HMP Whatton, HMP Featherstone, HMP & YOI Swinfen Hall). Also experience of delivering treatment in probation services during this time (Derbyshire Probation).
- Delivered and managed offending behaviour programmes. Assessment of suitability and need for various interventions e.g. sex offender treatment, domestic violence treatment, violence treatment, drug treatment. Writing risk assessments for parole and allocation of such reports to other team members. Giving evidence at parole hearings for indeterminate and life sentenced prisoners.
- Forensic mental health and personality disorder specific experience in secure and community settings. Involved in gatekeeping assessment of patients in prisons and non-forensic sites to assess suitability for detention in the secure forensic hospital.

Publications & selected presentations

Tully, R.J. & Bamford, J. (Eds.) (2025). *Case studies in forensic psychology: Diversity in clinical practice.* London, UK: Routledge.

Tully, R.J. & Illingworth, C. (2025). Cognitive assessment for criminal court of an adult male with a diagnosis of ADHD: assessment and implications. In R.J. Tully & J. Bamford (Eds.) *Case studies in forensic psychology: Diversity in clinical practice.* London, UK: Routledge.

Tully, R.J. (2025). Risk assessment in violent extremism and terrorism cases. In R.J. Tully & J. Bamford (Eds.) *Case studies in forensic psychology: Diversity in clinical practice.* London, UK: Routledge.

Bamford, J. & **Tully, R.J.** (2025). Forensic risk assessment in so-called 'honour'-based violence and abuse cases. In R.J. Tully & J. Bamford (Eds.) *Case studies in forensic psychology: Diversity in clinical practice.* London, UK: Routledge.

Mitchell, Z., Johnson, D., & **Tully, R. J.** (2025). The use of the Paulhus Deception Scale with forensic populations: A psychometric critique. *Journal of Forensic Psychology Research and Practice*. Online first.

Tully, R. J., Bohall, G., & Prescott, D. S. (Eds.) (2025). *Best Practices in Sex Offender Assessment and Management.* Switzerland: Springer.

Tully, R. J. (2025). Forensic risk assessment and online offending (sexual, stalking, and extremism). In C. Wise and J. Bamford (Eds.). *Understanding the technology behind online offending: A guide for professionals in the criminal justice system.* London: Taylor & Francis.

Peters, J. & **Tully, R. J.** (2024). Theoretische Basis für die Behandlung psychisch gestörter Straftäter*innen. In Völlm, B. & Schiffer, B. (Eds). *Forensische Psychiatrie: Rechtliche, lkinische und ethische Aspekte.* Springer. [Theoretical basis for the treatment of mentally disordered offenders]

Tully, R. J. & Bamford, J. (Eds). (2023). *Further case studies in forensic psychology.* London, UK: Routledge.

Tully, R. J. (2023). Forensic psychology and court processes. In Corteen, K., Steele, R., Cross, N. & McManus, M. (eds.) *Forensic Psychology, Crime and Policing: Key Concepts and Practical Debates.* Bristol: Policy Press.

Tully, R. J. (2023). Forensic psychology and prisons. In Corteen, K., Steele, R., Cross, N. & McManus, M. (eds.) *Forensic Psychology, Crime and Policing: Key Concepts and Practical Debates.* Bristol: Policy Press.

Bates, Y. & **Tully, R.J.** (2022). Supporting people with Autism Spectrum Conditions in prison. In Tyler, N. & Sheeran A. (Eds.). *People with Autism in the Criminal Justice and Forensic Mental Health System: A Handbook for Practitioners*. London, UK: Routledge.

Smethurst, A., Bamford, J. B., & **Tully, R. J.** (2021). A systematic review of recidivism rates of older adult male sex offenders. *Applied Psychology in Criminal Justice 16*(1), 23-51.

Ashworth, S., Mooney, P., Browne, K., & **Tully, R. J.** (2021). An Exploratory Analysis of a Scale to Measure Attitudes Towards Mentally Disordered Offenders. *Journal of Forensic Psychology Research and Practice.* DOI:10.1080/24732850.2020.1829448

Ashworth, S., Bamford, J., & **Tully, R.J.** (2020). The effectiveness of a CBT-based intervention for depression symptoms with a female forensic inpatient with cognitive disability and autism. *Journal of Forensic Psychiatry and Psychology.* DOI: 10.1080/14789949.2020.1754445

Rossdale, S., **Tully, R.J.,** & Egan, V.E. (2020). The HCR-20 in predicting violence in adult females: A meta-analysis. *Journal of Forensic Psychology: Research and Practice 20*(1), 15-52.

Marsden, J., Glazebrook, C., **Tully, R.J.,** & Völlm, B. (2019). Do adult males with antisocial personality disorder (with and without co-morbid psychopathy) have deficits in emotion processing and empathy? A systematic review. *Aggression and Violent Behavior 48,* 197-217.

Tully, R.J., Bamford, J., Wise, C., & Graham, M. (2019, June). *Detection, assessment, treatment, and the law for internet sexual offenders: current practice, challenges, & opportunities.* Workshop at the British Psychological Society Division of Forensic Psychology annual conference, Liverpool, 20.06.2019.

Tully, R.J. & Bamford, J. (Eds.) (2019). *Case studies in Forensic Psychology: Clinical assessment and treatment.* London, UK: Routledge.

Tully, R.J. (2019). Sexual deviancy: assessment for court. In R.J. Tully and J. Bamford (Eds.) *Case studies in Forensic Psychology: Clinical assessment and treatment* (25-47). London, UK: Routledge.

Tully, R.J. (2019). Mental health and violence: Forensic risk assessment and formulation. In R.J. Tully and J. Bamford (Eds.) *Case studies in Forensic Psychology: Clinical assessment and treatment* (133-148). London, UK: Routledge.

Tully, R.J. (2019, April). *Managing high risk sex offenders: a psychopathy case study.* Invited presentation at the Avon and Somerset MAPPA conference, Police Headquarters, Bristol, 01.04.2019.

Timmins, K., Evans, L. & **Tully, R.J.** (2018). Inter-Rater Reliability of the Short-Term Assessment of Risk and Treatability (START). *Journal of Forensic Psychiatry and Psychology,* 29(6), 968-998. DOI: 10.1080/14789949.2018.1523945

Ball, L., **Tully, R.J.,** & Egan, V.E. (2018). The influence of impulsivity and The Dark Triad in self-reported aggressive driving behaviours. *Accident: Analysis & Prevention 120,* 130-138.

Ashworth, S., Browne, K. & **Tully, R.J**. (2018). A systematic review exploring the quality and effectiveness of tools currently used to measure attitudes toward prisoner populations: Exploring reliability and validity. *Journal of Forensic Psychology Research and Practice 18*(1), 19-44.

Tully, R.J. (2018, June 8th). *Risk assessment of sex offenders maintaining innocence.* Invited presentation at National Association for the Treatment of Abusers (NOTA) clinical forum. Scotland, UK.

Tully, R.J. (May, 2018). *Parole following the Worboys case: a psychological perspective.* Invited presentation and panel member at the Prisoners Advice Centre annual panel debate. London, England.

Ashworth, S., & **Tully, R.J.** (2017). Autism awareness training for Youth Offending Team staff members. *Advances in Autism 3*(4), 240-249. DOI: 10.1108/AIA-04-2017-0010

Bothamley, S. & **Tully, R.J.** (2017). Use of the Social Problem Solving Inventory-Revised (SPSI-R) with forensic populations: A psychometric critique. *International Journal of Offender Therapy and Comparative Criminology.* Early cite. DOI: 10.1177/0306624x17734801

Tully, R.J. (2017, September 28th). *Sex offender treatment: What next?* Invited presentation at the Association of Prison lawyers (APL) Conference, London, UK.

Berry, L., **Tully, R.J.,** & Egan, V.E. (2017). A case study approach to reducing the risks of child sexual exploitation (CSE). *Journal of Child Sexual Abuse 26*(7), 769-784.

Bothamley, S., & **Tully, R.J.** (2017). Understanding revenge pornography: public perception of revenge pornography and victim blaming. Journal of *Aggression, Conflict and Peace Research 10*(1), 1-10.

Higgs, T., **Tully, R.J.,** & Browne, K.D. (2017). Psychometric properties in forensic application of the screening version of the Psychopathy Checklist. International *Journal of Offender Therapy and Comparative Criminology 62*(7), 1869-1887. DOI:10.1177/0306624X17719289

Higgs T., Carter, A.J., **Tully, R.J.,** & Browne, K.D. (2017). Sexual murder typologies: A systematic review. *Aggression and Violent Behavior 35*, 1-12. DOI:10.1016/j.avb.2017.05.004

Tully, R.J. & Bailey. T. (2017). Validation of the Paulhus Deception Scales (PDS) in the UK and examination of the links between PDS and personality. *Journal of Criminological Research, Policy and Practice 3*(1) 38-50. doi: 10.1108/JCRPP-10-2016-0027 Also presented at the British Psychological Society Division of Forensic Psychology annual conference, 14.06.2017, Bristol, UK.

Ashworth, S., Mooney, P., & **Tully, R.J.** (2017). A case study demonstrating the effectiveness of an adapted DBT program upon increasing adaptive emotion management skills, with an individual diagnosed with mild learning disability and emotionally unstable personality disorder. *Journal of Forensic Psychology Research and Practice 17*(1), 38-60

Green, K., Kukan, Z., & **Tully, R.J.** (2017). Public perceptions of 'negging': lowering women's self-esteem to increase the male's attractiveness and achieve sexual conquest. *Journal of Aggression, Conflict and Peace Research 9*(2), 95-105.

Kerr, N., **Tully, R.J.,** & Völlm, B. (2017). Volunteering with sex offenders: the attitudes of volunteers toward sex offenders, their treatment and rehabilitation. *Sexual Abuse: A Journal of Research and Treatment 30*(6), 659-675. doi: 10.1177/1079063217691964

Tully, R.J. & Barrow, A. (2017). Using an integrated, Cognitive Analytic Therapy (CAT) approach to treat intimate partner violence risk. *Journal of Aggression, Conflict and Peace Research 9*(2), 128-140.

Browne, K.D., Hines, M., & **Tully, R.J.** (2016). The differences between sex offenders who victimise older women and sex offenders who offend against children. *Aging and Mental Health 22*(1), 11-18. DOI:10.1080/13607863.2016.1202892

Ball, L., **Tully, R.J.,** & Egan, V. (2016). The SAPAS, personality traits, and personality disorder. *Journal of Personality Disorders 31*(3), 385-398.

Ashworth, S. & **Tully, R.J.** (2016). ASD In Forensic Settings: Hidden Populations Still Experience The 'Diagnosis Crisis'. *British Medical Journal.*

Ashworth, S., Mooney, P., & **Tully, R.J.** (2016). Adapted DBT Programme for Individuals with Intellectual Disabilities and Problems Managing Emotions: Staff Awareness Training. *Advances in Mental Health and Intellectual Disabilities, 10* (3), 185-198. DOI 10.1108/AMHID-12-2015-0053.

Tully, R.J. (2016, April). *Invited case discussion panel member.* Association of Prison Lawyers Annual Conference. 20.04.2016.

Evans, L. & **Tully, R.J.** (2016). The Triarchic Psychopathy Measure (TriPM): Alternative to the PCL-R? *Aggression and Violent Behaviour, 27*, 79-86. doi:10.1016/j.avb.2016.003.004

Tully, R.J. (2016). *Clinical review of the MCMI-IV*. Pearson.

Tully, R.J. (2015, Dec). *Peter Sutcliffe cannot have been 'cured' of schizophrenia.* The Conversation.

Pryboda, J., **Tully, R.J.,** & Browne, K.D. (2015). Is the Risk Matrix 2000 applicable to intellectually disabled sex offenders*? Aggression and Violent Behaviour, 25,* 184-190. doi: 10.1016/j.avb.2015.08.002

Tully, R.J. & Browne, K.D. (2015, May) *Risk assessment in a time of austerity: Debate.* Royal College of Psychiatrists Biannual Meeting, invited debate.

Schamborg, S. & **Tully, R.J.** (2015). A systematic review of the effectiveness of anger management interventions among adult male offenders in secure settings. *Archives of Forensic Psychology 1*(2), 28-54.

Schamborg, S., **Tully, R.J.,** & Browne, K.D. (2015). The use of the State-Trait Anger Expression Inventory-II with forensic populations: A psychometric critique. *International Journal of Offender Therapy and Comparative Criminology, 60*(11), 1239-1256. doi: 10.1177/0306624X15577932

Tully, R.J., Browne, K.D., & Craig, L.A. (2015). An examination of the predictive validity of the Structured Assessment of Risk and Need Treatment Needs Analysis (SARN-TNA) in England and Wales. *Criminal Justice and Behaviour, 42*(5), 509-528.

Tully, R.J. (2015, March). *How can 400 sex offenders go missing?* The Conversation.

Tully, R.J., & Browne, K.D. (2015). Appraising the Risk Matrix 2000 sex offender risk assessment tool. *International Journal of Offender Therapy and Comparative Criminology 59*(2), 211-224. doi:10.1177/0306624X13508928

Brown, S., & **Tully, R.J.** (2014). Components underlying sex offender treatment refusal: An exploratory analysis of the Treatment Refusal Scale-Sex Offender version. *Journal of Sexual Aggression 20*(1), 69-84. http://dx.doi.org/10.1080/13552600.2012.759282 (also presented as oral paper at Coventry University Forensic Psychology Conference, 14th Sept 2012, Coventry, England, UK).

Tully, R.J. (2013). *Sex offender treatment and risk assessment: A case study of an individual on the NHS/NOMS personality disorder offender pathway.* Invited oral paper at the Nottinghamshire Healthcare & University of Nottingham Annual Trent Study Day, 12th July 2013, Rampton Hospital, Nottinghamshire, UK.

Tully, R.J., Chou, S.C., & Browne, K.D. (2013). A systematic review on the effectiveness of sex offender risk assessment tools in predicting sexual recidivism of adult male sex offenders. *Clinical Psychology Review 33,* 287-316. http://dx.doi.org/10.1016/j.cpr.2012.12.002 (Also presented as poster at the British Psychological Society Division of Forensic Psychology Annual Conference, 24th-26th June 2012, Cardiff, Wales, UK).

Tully, R.J., & McCaw, S. (2012). *Developments in prison-based programmes.* Invited oral paper presented at Coventry University Forensic Psychology Conference, 14th Sept, Coventry, England.

Media appearances/contributions (from the last 5 years)

Cold Case UK: Fuller, Crime+Investigation UK, October 2025
I provided commentary around sexual deviance, murder, and offending.

Cold Case UK: The Town Path Rapist, Crime+Investigation UK, October 2025
I provided commentary around a case of rape that was solved years later through familial DNA matching.

LBC Radio, 03.10.2025
Live interview in light of the terrorist attack at a Synagogue in Manchester.

The Mirror, 24.08.2025
I provided commentary regarding covert sexually motivated offending of adult males.

BBC Three Counties Radio, 06.08.2025
Live interview whereby I discussed the importance of education in prisons for rehabilitation.

The Conman Killer, Channel 5, July 2025
True crime documentary in which I provided discussion on a case of murder where the perpetrator was skilled in conning and manipulating others.

The Body in Room 203, Channel 5, July 2025
True crime documentary in which I provided analysis and discussion of a partner homicide that was staged to look like a suicide.

LBC Radio, 12.06.2025
Live interview regarding trauma in extreme incidents for survivors, and family members of the deceased, in light of a recent plane crash.

BBC Radio 5 Live, 06.06.2025
Panel discussion hosted by Nicky Campbell regarding children who have committed serious crimes, in light of a high-profile case.

LBC Radio, 06.06.2025
Interviewed by Nick Ferrari regarding youth serious offending in light of a high-profile case.

Britain's Countryside Killers, True Crime channel, aired Spring 2025
I provided on-screen expert narrative about murder cases in several episodes.

BBC Radio 4 Woman's hour, 24.03.2025
Live interview about issues affecting boys and teenagers in light of the issues raised in Netflix show 'Adolescence'.

Belfast newsletter (online news), 06.03.2025
Provided comment on a case involving a perpetrator convicted of multiple rape offences.

BBC News (TV), 20.12.2024
Live interview regarding the impact of sex offending and rehabilitation prospects for perpetrators, in light of a high-profile French case involving over 50 perpetrators.

BBC News (TV), 19.12.2024
Live interview regarding sexual offending in light of a high-profile French case involving over 50 perpetrators.

LBC radio, 12.12.2024
Interviewed live regarding a recent case of a child murdered by her father and caregivers.

Tyla article on 'true crime', December 2024
Provided input to a media article citing the dangers associated with amateur sleuths and discussion of interest in 'true crime'

I'll be watching you, documentary, Paramount+, November 2024
True crime documentary in which I provided analysis of the psychology involved in voyeurism. 2-episode docuseries.

Sweetpea, drama series, Sky Atlantic, aired 2024
Provided character consultation to the production company at an early stage regarding the lead character who commits murder and other crimes.

LBC radio, 30.07.2024
Interviewed regarding potential contributory factors to serious crime in light of the murder of children in Southport, UK.

Business Insider article, 09.05.2024
Provided insight into why people may be interested in true crime and the harm that can be caused by 'armchair detectives'.

LBC radio, 01.05.24
Interviewed regarding knife crime.

TalkTV live interview, 04.03.2024
Interviewed by Vanessa Feltz in light of the report into the murder of a woman by a serving police officer.

TalkTV live interview 29.02.2024
Interviewed by Vanessa Feltz about the dangers and impact of drink spiking, and why people do this.

TalkTV live interview 26.02.2024
Interviewed by Vanessa Feltz regarding the murder of a woman by a serving police officer.

Channel 4 news interview 06.02.2024
Discussion of difficulties where prisoners are not transferred to psychiatric hospital in a timely manner in light of a recent thematic report on the problems associated with this.

Sky News live interview, 24.01.2024
Discussion of serious violence and mental health, and hospital orders versus prison in light of a recent triple homicide case.

BBC Radio 5 interview for online article by Nihal Arthanayake, 2023
Contributed to an article about road rage / driving aggression:
https://www.bbc.co.uk/programmes/articles/4dZqqP7DcSV3rbcdfyvvRPm/can-road-rage-be-stamped-out

Caught on Camera documentary, Season 6, May – June 2023
Discussion, across several episodes, of reasons for violence and offending of various types for documentary series.

Times Radio live interview 17.03.2023
Discussion about allegations of rape and false allegations in light of a recent case.

We Hunt Together Season 2, 2022, Alibi
Provided character and script consultation for season 2 of this crime drama.

Sky Crime documentary series 'What the killer did next', Season 2, Winter 2022-2023
Contributed to documentary series regarding cases of murder.

Crime + Investigation documentary series 'Murdertown', Season 4, 2022-2023
Discussion of criminal behaviour in the context of several episodes set in different towns.

BBC TV documentary series 'Expert Witness', Season 1, 2022
Documentary series for TV on the role of expert witnesses in contributing to criminal investigation and prosecutions.

BBC news online article on public interest in 'true crime', 22.07.2022
Contributed to an article about the increase in interest in true crime, especially from women. https://www.bbc.co.uk/news/business-61948546

BBC3 TV documentary 'Dating's Dangerous Secrets', February 2022
Discussion about the dangers of using dating apps and online methods of meeting a partner.

BBC Radio Ulster, 06.02.2022
Discussion with panel about the purpose of prison, e.g. punishment and rehabilitation.

Documentary 'SAT1 investigative: new leads in the "Maddie" case', October 2021, aired January 2022
I provided input on behaviours and motivations related to sexual offending.

ITN productions / Channel 5 documentary 'The abduction of Lesley Whittle', aired 11.10.2021
Commentary on psychological aspects of this non-recent case.

BBC Radio Nottingham, 25.10.2021
Discussion with presenter on the topic of drink spiking and sexual offending.

BBC Radio 5 live, 14.08.2021
Discussion with presenter about 'incel' ideology-based mass shooting in Plymouth, UK.

BBC Radio Kent, 17.02.2021
Discussion with presenter and retired police officer about unsolved murders, and why people might admit to offences much later on in their sentence.

BBC radio 'Talkback' show, 16.09.2020
Panel discussion regarding serial killing and the 'Des' ITV drama of the Dennis Nielson murders.

Times Radio with Mariella Frostrup, 25.08.2020
Expert discussion about serial killing and murder.

Netflix drama series 'White Lines', series aired Spring 2020
I consulted on a lead character with a history of trauma and attachment problems, specifically relating to her clinical presentation and therapy.

Channel 5 documentary series, 'New: Cops, Robbers & Videotape', aired 22.02.2020
Expert commentary on criminal behaviour.

New Scientist, 14.02.2020
Interviewed to contribute to an article on misuse / inappropriate use of psychological tests in court.

Radio 4 documentary; 'Crisis inside', January 2020
Contributed to documentary regarding extremism / terrorism offenders and psychological risk assessment.

Pre-2020 media contributions available on request

Appendix II Index

Pages	Document	URN
1 - 148	HCR-20 V3: Assessing Rosk for Violence, User Guide (Douglas, Hart, Webster & Belfrage, 2013)	WITN0358002

Appendix III: Glossary of terms

Actuarial risk assessment tools are non-discretionary, algorithmic approaches concerned with prediction.

Area under the curve (AUC) is a common statistic calculated in research when assessing the predictive accuracy of risk assessment tools.

British Psychological Society (BPS) is a learned body for psychologists but is not the statutory / professional regulator.

BVC is an actuarial violence risk assessment tool comprising a 6-item checklist, which was developed in Norway.

Community Treatment Orders (CTOs) are legal orders under the Mental Health Act 1983 (amended 2007) governing the care and treatment of certain patients in the community.

DASA-IV is an actuarial violence risk assessment tool for inpatients.

FAM (Female Additional Manual) is a set of additional guidelines written for supplementing the use of the **HCR-20v3** with women.

Forensic Psychologist is a protected title under the **HCPC**; a person must be on the HCPC register to use this title. The training route is described to some degree in the report.

Formulation of violence risk is an attempt to make sense of the violent behaviour and is a hypothesis exploring aetiology, links, and causation.

HCR-20v3 is a violence risk assessment tool following structured professional judgment approach. This is described in much more detail in the report.

Health and Care Professions Council (HCPC) is the statutory regulator of practitioner psychologists in the UK.

Imminence of violence risk is 'how soon' the violence may occur.

NICE (National Institute for Health and Care Excellence) guidelines are evidence-based recommendations for health and social care services in England and Wales.

OASys (Offender Assessment System) is a computerised risk and needs tool used by probation services in England and Wales, which incorporates actuarial risk tools within it based on information inputted by probation practitioners.

OVP (OASys Violence Predictor) is an actuarial violence risk assessment part of probation's OASys assessment.

Parole Board of England and Wales serve the function of assessing whether prisoners meet the test for release or open conditions in cases referred to them by the Secretary of State.

Predictive validity in violence risk assessment typically looks at whether a score on a risk tool, or risk label (e.g. low, moderate, high) accurately predicts violence (e.g. do the people with higher risk groups or scores reoffend more frequently, seriously, or quickly than lower risk people). Various statistics can be used to explore this concept.

Protect International is the company that the authors of the HCR-20v3 operate.

Risk factors for violence are things that may influence violence by playing a causal or contributory role to a person's violence decision making, or it may be that a risk factor is something that complicates or affects risk management in some way.

SAVRY (structured assessment of violence risk in youth) is a **structured professional judgment (SPJ)** tool to assess violence risk in youth up to age 18.

Scenario planning in violence risk assessment involves considering what future violence might look like (e.g. in a repeat, twist, or escalation compared to past violence) which can then inform risk management strategies. It is not a 'prediction', it is what 'could' happen.

Severity of violence risk is how severe physical violence could be (e.g. life threatening / lethal) or level of psychological harm.

Structured professional judgment (SPJ) sometimes also called structured clinical judgment (SCJ) is an approach to risk assessment and management that is preventative and considers the professional's judgment within an empirically developed framework. This is described in more detail in the report.

Unstructured clinical judgment (UCJ) is an approach to risk assessment that does not involve formal structure, and is based on the clinician's opinion and intuition. This is described more in the report.

WITN0358001_0077

Violence risk assessment tools are described in more detail in 2.2 of the report but in essence are formal approaches to risk assessment of violence.

VRAG / VRAG-R is an actuarial violence risk tool.

Appendix IV: Potential conflicts of interest

As VC's offending was in Nottingham, I have considered my actual or potential for contact with services and professionals in the nearby area. I have worked in Nottingham and the surrounding areas. I am not aware of ever having had contact with or knowledge of VC or any of the victims.

University of Nottingham

I studied at the University of Nottingham across 2011-2012 on their professional Doctorate in Forensic Psychology (DForenPsy; this is a HCPC approved route to qualify to apply for registration as a forensic psychologist in the UK). Once qualified when working in Nottinghamshire Healthcare NHS Trust as detailed below, I supervised several of the university's DForenPsy students who completed placements in the service I worked in. I subsequently worked on the DForenPsy programme as Assistant Professor in formal employment (2014 - 2016) and have provided honorary teaching/lectures outside of that employment. I have acted as an external clinical practice examiner to the DForenPsy (2025). A nominal sessional fee was paid for the examinations for which I believe the University will have completed checks e.g. ID and may have involved me being considered a sessional worker of some sort. I have no ongoing contract/obligations with the university for further work, and I complete tax self-assessment. I do not rely on any income associated with the University. I am aware from the media coverage that 2 victims attended the University of Nottingham. I have no knowledge of the victims through this work. I do not consider that my history with the University of Nottingham undermines my ability to provide expert evidence, and my recent input was limited to examination of Forensic Psychology trainees.

Nottinghamshire Healthcare NHS Trust and other trusts

I was an honorary forensic psychologist in training across 2011 and 2012 in the low secure Wells Road Centre and the associated community forensic team. In December 2012 – approx. March 2014 I was a full-time paid employee of the Trust. I am not currently employed by the trust. I have no knowledge of the VC case through my past employment, and I do not consider that this undermines my ability to provide independent expert evidence. I may have had contact with people involved in this case but am unaware of this as I do not know who was involved. I exclusively worked in forensic services. I am unaware if VC was seen in forensic or non-forensic services in Nottingham. I am unaware if VC had been known to other trusts but it may be relevant to highlight here that I have trained people in risk assessment across a variety of trusts including neighbouring trusts.

Training delivery to professionals who may work in or be associated with Nottingham (e.g. Nottinghamshire Healthcare NHS Trust and University of Nottingham)

I deliver training to a range of professionals across the UK and internationally. This has definitely included people from Nottinghamshire Healthcare NHS Trust who have booked onto our open training events including that for HCR-20v3 and other risk tools. My training company has

therefore been a 'supplier' to the Trust who have paid the company for their employees to attend training. Trainee psychologists or others from the University of Nottingham have also attended training. I have previously provided this training to trainees when I worked at the University, and some may have attended open events self-funded. I am not aware if trainees were on placement in the Trust or if they since became employed by the trust. I am not reliant on the University or the Trust for income. I have no knowledge of having trained anyone involved in this case (although I do not currently have details of those involved). I do not consider that this undermines my ability to provide independent expert evidence.

HCR-20v3 tool itself

I provide paid-for training in this tool other tools. I pay the authors' company a license fee in relation to this work. I also use this tool in clinical practice, amongst other tools in my more general work as a HCPC Registered Forensic Psychologist. This work means that I am well placed to provide an expert view in relation to the tool's use. In line with me training others in the tool's use and my own use of this tool in some of my work, it follows that some of my income is linked to the tool. Training others in the tool and using it in my clinical and expert practice involves expert knowledge of both its strength and weaknesses. My income does not depend on the efficacy of the HCR-20v3 as a tool. I did not create / author the tool. I do not consider my training delivery or use of the tool to compromise my ability to respond to these instructions, rather I consider it assists me in commenting both from a clinical practice and research / literature-based perspective.

Media input

I regularly provide comment to the press e.g. TV news channels. One entry on my CV was a brief interview for Sky News on 24.01.2024 which involved the VC case. I recall that the focus of the interviewer was on hospital orders, and I was asked related questions. I did not obtain any knowledge of the case through this and do not consider this to be a conflict affecting my independence. I cannot recall exactly what I was asked or said, but when I make media appearances, I usually comment generally on the themes involved (in this case violence, mental illness, and hospital orders) and tend to express empathy for victims (direct and wider). I would reasonably hypothesise this is what I discussed in the TV news interview which will have lasted a few minutes in total.

Appendix V: Statement of Truth,

I, Dr Ruth Tully, declare through my signature within this report that:

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

(Statement of Truth wording taken from Letter of Instruction dated 23.09.2025)

__REPORT ENDS__